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IN THE

Supreme Court of the United States

MAY TERM, 1982

MARY C. KRANDA, *Appellant*

vs.

HOUSER-NORBORG MEDICAL CORPORATION
and KEIM T. HOUSER, M.D., *Appellees*

ON APPEAL FROM THE COURT OF APPEALS OF INDIANA

JURISDICTIONAL STATEMENT

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HOUSER-NORBORG MEDICAL CORPORATION
and KEIM T. HOUSER, M.D., *Appellees*

JURISDICTIONAL STATEMENT

Appellant, Mary C. Kranda, (plaintiff below) appeals from the final judgment of the Court of Appeals of Indiana which holds that the Indiana Medical Malpractice Act, *Ind. Code Ann.* §16-9.5-1-1 through §16-9.5-10-5 (Burns), is constitutional, and does not violate Appellant's 5th, 7th, and 14th Amendment rights.

The opinion of the Court of Appeals of Indiana is reported at 419 N.E.2d. 1024.

QUESTION PRESENTED

Does the Indiana Medical Malpractice Act, *Ind. Code Ann.* §16-9.5-1-1 through §16-9.5-10-5 (Burns), violate the due process, equal protection, and jury trial guarantees of the Constitution of the United States of America as applied to the states through the 14th Amendment to the Constitution of the United States of America.

PARTIES

All the parties to this case are listed in the caption.

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OPINION BELOW

This cause was decided by an opinion of the Court of Appeals of Indiana and is to be found at 419 N.E.2d. 1024.

CONCISE STATEMENT OF GROUNDS

I. This appeal is for the purpose of challenging the constitutionality of the Indiana Medical Malpractice Act.

II. This is the appeal of a medical malpractice case which resulted in a defendant's verdict. Judgment was entered upon the verdict on December 5, 1979, by the St. Joseph Superior Court, South Bend, Indiana.

This case was appealed to the Court of Appeals of Indiana. The Court of Appeals held the Act was constitutional in a written opinion which was rendered on the 5th day of May, 1981. The opinion is reported in full at 419 N.E.2d. 1024. The Indiana Supreme Court denied transfer on the 28th day of January, 1982. The opinion of the Court of Appeals of Indiana was filed with the Clerk of the St. Joseph County Superior Court on February 9, 1982.

A Notice of Appeal to the United States Supreme Court was filed with the Clerk of the Court of Appeals of Indiana on the 31st day of March, 1982.

III. The grounds on which the jurisdiction of this Court is invoked is in 28 U.S.C. §1257(2).

CONSTITUTIONAL AND STATUTORY PROVISIONS

The provisions of the Constitution of the United States of America that this case involves are:

AMENDMENT 5

> No person shall...be deprived of...property, without due process of law.

U.S. CONST. amend V.

AMENDMENT 7

> In suits at common law...the right of trial by jury shall be preserved.

U.S. CONST. amend. VII.

AMENDMENT 14

> ...No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of...property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV.

The provisions of the Indiana Medical Malpractice Act are as follows:

See *Ind. Code Ann.* §16-9.5-1-1 through and including §16-9.5-10-1 (Burns). The statute is set out in our Appendix.

A CONCISE STATEMENT OF THE CASE

The Appellant, Mary C. Kranda, was a patient of the Appellee Keim T. Houser, M.D., who specialized in the field of obstetrics and gynecology, including gynecological surgery and who was serving as agent of Houser-Norborg, a medical corporation.

Keim T. Houser, M.D., was and is a physician authorized to practice medicine in the State of Indiana and represented himself to the public, including the Appellant Mary C. Kranda, as a specialist in obstetrics and gynecology.

Mary C. Kranda, consulted with Keim T. Houser, M.D., who examined and treated her and recommended surgery for the removal of warts from the area of her vagina.

On the 6th day of February, 1976, at Memorial Hospital of South Bend, Indiana, Keim T. Houser, M.D., performed

surgery on Mary C. Kranda to remove the warts as well as a cyst or abscess.

The rectum of Mary C. Kranda was entered during the surgery, resulting in the development of a rectal fistula, (i.e., a hole between the inside of the anus and the skin which was beside the rectum on the left side towards the front of the rectum) and this hole allowed feces and gas to escape from her bowels in such a way as to by-pass the normal muscle mechanism of her rectum and deprive her of bowel control.

That as a result, Mary C. Kranada required numerous surgeries and a permanent colostomy. She incurred physical and mental pain and suffering, medical and hospital bills, lost wages, and was permanently injured.

Mary C. Kranda will be required to undergo further surgeries and medical treatment in the future.

She was required by the Act to first submit her claim to a medical panel. The medical panel members each submitted a separate opinion in which they opined that there was no malpractice. Plaintiff attempted to keep these opinions from being introduced into evidence. She also objected to the panel members being allowed to testify at the trial.

The constitutionality of the Indiana Medical Malpractice Act and the opinion of the medical panel was challenged at the trial level by a Motion In Limine which sought to bar the use of the panel opinion as evidence at the trial. Plaintiff's motion was denied by the Trial Court. The panel opinion was objected to at trial, but was admitted into evidence by the Trial Court. The testimony of the panel members was objected to at trial. The panel opinion was objected to again in the Motion to Correct Errors which was overruled by the Trial Court. The constitutionality of the panel opinion and the propriety of its use as evidence at trial was presented to the Court of Appeals of Indiana and

the Court of Appeals ruled that the Indiana Medical Malpractice Act was constitutional and the opinion of the panel was properly admitted into evidence. The Constitutional issues were again raised in Appellant's Petition For Transfer To the Indiana Supreme Court and said petition was denied.

SUBSTANTIAL NATURE OF THE CONSTITUTIONAL ISSUES PRESENTED

Appellant Mary C. Kranda's appeal is from the judgment of the St. Joseph Superior Court, South Bend, Indiana, (Appendix A) and the decision of the Court of Appeals of Indiana (Appendix B) which holds that the Indiana Medical Malpractice Act (Appendix C) is constitutional. A certified copy of the opinion of the Indiana Court of Appeals was filed with the Clerk of the St. Joseph County Superior Court on February 9, 1982. It is Appellant's contention that the Indiana Medical Malpractice Act, as applied to the facts of this case, and/or applied generally is a procedural monstrosity which has resulted, and continues to result in the gross deprivation of the fair trial rights of civil plaintiffs in medical malpractice cases (Appendix D) and is in clear violation of the Constitution of the United States of America.

The Indiana Medical Malpractice Act requires a claimant seeking damages against a qualified health care provider to submit to a costly, time-consuming procedure, before a board whose voting members are all health care providers and which has no power to resolve the controversy, as a predicate to commencing a civil suit to seek a judicial resolution of the controversy. *Atlas Roofing Co. v. Occupational Safety & Health Review Com.*, 430 U.S. 442, 51 L.Ed.2d 464, 97 S.Ct. 1261 (1977).

The Indiana Medical Malpractice Act is vague to the point of being capable of an interpretation violative of constitutionally protected rights by requiring a procedure

to be followed that does not provide a method of resolving legal, procedural, and evidentiary disputes. There is no effective way to compel defendants or the panel to do anything to move the case along. Plaintiff is at the mercy of the defendants, their counsel, the members of the malpractice board, and its chairman. *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980). As a result, these cases get delayed to death. (Appendix D). *State ex rel. Cardinal Glennon Memorial Hospital v. Gaertner*, 583 S.W.2d 107 (Mo. 1979).

The Indiana Medical Malpractice Act violates equal protection of laws under the Fourteenth Amendment of the United States Constitution for it creates an artificial, arbitrary, and unreasonable legislative classification between persons subjected to its provisions. *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); *Zobac v. Southeastern Hospital District*, 382 So.2d 829 (Fla. 1980); *Wright v. Central Du Page Hospital Assn*, 347 N.E.2d 736 (Ill. 1976). No other class or group of defendants gets similar procedural protection.

The monetary limitation upon a plaintiff as provided by the Indiana Medical Malpractice Act is an unwarranted violation of the plaintiff's constitutional right to trial by jury in that a jury is not permitted to assess reasonable compensation on an individual basis and the limitation on damages creates an impermissible, irrebuttable presumption by depriving an injured person of the right to prove that his individual claim is not excessive, even though it exceeds the statutory limitation. *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Jones v. State Board of Medicine*, 555 P.2d 399 (Idaho 1976).

The Indiana Medical Malpractice Act violates the due process rights found in the United States Constitution by preventing a patient from recovering reasonable damages commensurate with the injury incurred. *Simon v. St. Elizabeth Medical Center*, 355 N.E.2d 903 (Ohio 1976); *Carson v. Maurer*, 424 A.2d 825, 80 A.L.R.3rd 583 (N.H. 1980).

The Indiana Medical Malpractice Act violates the right to trial by jury as guaranteed by the Seventh Amendment of the United States Constitution by increasing the burden of proof imposed upon plaintiff in overcoming the medical review panel's opinion. *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980); Appendix D.

The Indiana Medical Malpractice Act violates the plaintiff's constitutional right to a trial by an impartial jury in that the medical review panel is composed of doctors and colleagues of the defendant who benefit by the very existence of the Medical Malpractice Act. These fellow-doctors and colleagues also benefit directly and indirectly by a finding of "no malpractice" because a negative finding will serve to keep down the insurance premiums paid by health care providers including the members of the medical review panel. *Simon v. St. Elizabeth Medical Center*, 355 N.E.2d 903 (Ohio 1976).

The Indiana Medical Malpractice Act, *Ind. Code Ann.* § 16-9.5-1-1, *et. seq.* (Burns), in general, and as applied to this claim, violates due process of law under the Fourteenth Amendment to the United States Constitution.

The Fourteenth Amendment to the Constitution of the United States in part says:

> No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend., XIV §1.

Said Act has a substantial chilling effect on the exercise of constitutionally protected rights, including the right to redress for injuries, the right of access to the courts, and the right of trial by jury, by requiring a claimant seeking damages against a qualified health care provider to submit

to a costly, time-consuming procedure, before a board which has no power to resolve the controversy, as a predicate to commencing a civil suit to seek a judicial resolution of the controversy. *Carter v. Aparteman*, 335 So.2d 802 (Fla. 1976); *American Bank & Trust Co. v. Community Hospital of Los Gotos-Saratoga, Inc.*, 163 Cal.Rptr. 513 (1980).

The provisions of the Indiana Medical Malpractice Act, *Ind. Code Ann.* § 16-9.5-1-1, *et. seq.* (Burns), imposes a procedure prohibitively costly to the potential plaintiff and that is unnecessarily time-consuming as a predicate to commencing a civil suit for damages. U.S. CONST. amend. V and XIV. Plaintiff must first submit his claim to a medical review panel which has absolutely no power to resolve the controversy.

There can be no argument that plaintiff in this action, as well as all potential plaintiffs seeking recovery against health care providers qualified under the Act, are entitled to seek redress for their injuries, access to the courts, and the availability of a trial by a jury of their peers, if they so desire. These are fundamental rights and should remain inviolate. U.S. CONST. amend. V, VII, and XIV.

Yet, before plaintiffs are allowed to exercise any of these rights they must first submit their claim to a medical review panel for the rendering of an expert opinion. *Ind. Code Ann.* § 16-9.5-9-2 (Burns). By submitting a claim to a medical review panel the Act contemplates that the parties submit evidence, in written form "...medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties and other form of evidence allowable by the medical review panel. Depositions of parties and witnesses may be taken prior to the convening of the panel." *Ind. Code Ann.* § 16-9.5-9-4 (Burns). Thus, plaintiffs are forced to incur the time and expense of almost completely preparing a case for trial before the first pleading is even filed. When considered in light of the

economics of maintaining an action at law, some potential plaintiffs, with meritorious claims, will be dispelled from seeking redress for the wrongs done to them simply because the additional time and expense inherent in the Act makes it economically infeasible for them to do so. In short, the Act, by its very nature, has the effect of chilling potential plaintiffs in their exercise of constitutionally protected rights. *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); *Graley v. Satayatham*, 343 N.E.2d 832 (Ohio 1976).

The requirement of the screening panel also violates due process by making it impossible to litigate a malpractice claim unless the plaintiff has as much as $1,250.00 to pay the panel's expenses *Ind. Code Ann.* § 16-9.5-9-10 (Burns). The Arizona Supreme Court recently has found unconstitutional a provision of that State's malpractice screening act which required a plaintiff *unsuccessful* before the panel to post a $2,000.00 bond:

> As to the indigent, the statute violates the Arizona constitutional privileges and immunities clause...by denying access to the courts. As to the non-indigent, it places a heavier burden upon his access to court and therefore violates the same clause of the Arizona Constitution.

Eastin v. Broomfield, 570 P.2d 744, 754 (Ariz. 1977). To the same effect, the Supreme Judicial Court of Massachusetts upheld a $2,000.00 bond requirement because the Trial Court had the discretion to reduce the amount. *Paro v. Longwood Hospital*, 369 N.E.2d 985 (Mass. 1977). These cases are particularly forceful because they dealt with pretrial burdens placed on litigants whose claims the panel found unjustified. Under the Indiana statute, the burdens are *greater* for the plaintiff who has somehow convinced even his physician-judges of the validity of his claim.

The State does have the power to regulate in this area, but in so doing that power "must be so exercised as not, in attaining a permissible end, unduly to infringe the

protected freedom." *Cantwell v. Connecticut*, 310 U.S. 296, 304 (1940) (dealing with the effect of a state statute on the freedom of speech).

The purpose of procedure is to establish a method whereby people, may submit their controversies to a court of law for resolution. This purpose is above all else, central to the constitutional administration of justice. The Indiana Medical Malpractice Act, *Ind. Code Ann.* § 16-9.5-1-1, *et. seq.* (Burns), by requiring the submission of all claims to a medical review panel violates its cardinal principle. The panel has the power to render what amounts to nothing more than an expert opinion. The panel cannot resolve the controversy and hence does not justify the additional delay in a speedy administration of justice. In other words, justice can be administered equally well, and more expeditiously, without having to submit to the provisions of the Indiana Medical Malpractice Act.

The Supreme Court of Missouri, when confronted with very similar state constitutional and statutory provisions, held that such a precondition to court access was unconstitutional. *State ex rel. Cardinal Glennon Memorial Hospital v. Gaertner*, 583 S.W.2d 107 (Mo. 1979). *See* also *People ex rel. Christiansen v. Connell*, 118 N.E.2d 262 (Ill. 1954); *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980).

The seriousness of this delay is evident from the facts officially reported by the Indiana Medical Malpractice Commission on December 31, 1981 (Appendix D). The difficulty of forming panels means most cases will experience delay of *over two years*. In 1977, 141 claims were filed but as of December 31, 1981, only 71 were closed. Of the 401 complaints filed in 1980, only 44 had received a panel opinion and 110 were still waiting for a panel to be formed (Appendix D). No wonder the medical community likes the Act. They have effectively stopped plaintiff short of the courthouse door. *Kinsella v. United States*, 361 U.S. 234, 4 L.Ed.2d 268, 80 S.Ct. 297 (1960); *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980).

Of course, legislative modification of the substantive law will sometimes complicate the plaintiff's task in seeking a remedy. The Indiana Medical Malpractice Act does not openly excuse medical torts or breaches of contract; instead it lays procedural obstacles in the path to justice. The situation would be entirely different if the legislature simply modified the common law, as it did with respect to the Automobile Guest Statute. *Sidle v. Majors*, 264 Ind. 206, 341 N.E.2d 763 (1976); *Atlas Roofing Co. v. Occupational Safety & Health Review Com.*, 430 U.S. 442, 51 L.Ed.2d 464, 97 S.Ct. 1261 (1977).

Some modifications in the law may fairly burden those who seek their remedy. The commonly accepted test, developed in the context of Workman's Compensation Law, is that the plaintiff's common law remedies in court may be forestalled only if a non-judicial scheme provides some *quid pro quo*. Thus, the United States Supreme Court upheld the original Workman's Compensation Laws because the injured worker "has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of damages." *New York Central R.R. Co. v. White*, 243 U.S. 188, 201, 61 L.Ed. 667 (1917). Cf. *Warren v. Indiana Telephone Co.*, 271 Ind. 93, 26 N.E.2d 399 (1940).

Applying this principle to medical malpractice screening panels, it appears that the only benefit promised the plaintiff is the admissibility of a favorable panel report (for which, of course, the Indiana plaintiff must pay). Even this small "benefit" is highly illusory according to the official report of the Department of Insurance. Since the inception of the Malpractice Act there have been a total of 1,584 malpractice claims filed, 248 panel opinions rendered, and of those only 32 have resulted in a panel finding of malpractice. Only twenty-nine (29) payments have been paid from the Patients Compensation Fund since its inception. (Appendix D). Thus, even the most resolute plaintiff is forced to go to court, in most cases, with his

claim burdened by the pox of a judicial appearing finding of "no medical malpractice," and worn down by prolonged delay and expense. A fair reading of the Year End Report of the Patients Compensation Division, Department of Insurance, dated December 31, 1981, will lead one inescapably to the conclusion that the Act has created a procedural quagmire that has effectively prevented a malpractice plaintiff from seeking a civil remedy. *Washington v. Davis*, 426 U.S. 229, 48 L.Ed.2d 597, 96 S.Ct. 2040 (1976); *Marshall v. Jerrico Inc.*, 446 U.S. 238, 64 L.Ed.2d 182, 100 S.Ct. 1610 (1980); *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980).

The Indiana Medical Malpractice Act, *Ind. Code Ann.* § 16-9.5-1-1, *et. seq.* (Burns), in general, and as applied to this matter violates equal protection of laws under the Fourteenth Amendment to the United States Constitution for it creates an artificial, arbitrary, and unreasonable legislative classification between persons subjected to its provisions.

The Fourteenth Amendment to the United States Constitution states in part:

> No state shall deny...to any person within its jurisdiction the equal protection of laws.

U.S. CONST. amend. XIV, §I.

The clause in the federal constitution forbidding the States to deny equal protection of the laws, and the provision of Indiana's Bill of Rights prohibiting the granting of special privileges and immunities, are both aimed at unreasonable, artificial, and arbitrary legislative classifications, and both guarantee the treatment alike, in the same place and like circumstances and conditions, of all persons subjected to state legislation. *Davis Const. Co. v. Board of Com'rs of Boone County*, 192 Ind. 144, 132 N.E. 629 (1921). The gist of the provision in the federal constitution is to subject all to equal laws applying to all

alike in the same situation. *Burnett v. Camden*, 253 Ind. 354, 255 N.E.2d 650 cert. den., 90 S.Ct. 2202, 397 U.S. 901, 26 L.Ed.2d 556 (1970). This is not to say that the State must treat all people in precisely the same manner; however, the legislative power to classify persons for legislation is subject to the limitation that the classification must have a reasonable basis and operate equally on all within a class, and the reason for the classification must inhere in the subject-matter and be natural and substantial. *Selvage v. Talbott*, 175 Ind. 648, 95 N.E. 114 (1911). There must be some inherent and substantial difference, germane to the subject and legislative purpose, between those included and those excluded. *State v. Middleton*, 215 Ind. 219, 20 N.E.2d 509 (1939). No such justification for the classifications set up under the Indiana Medical Malpractice Act exists, as a result, said Act should be deemed constitutionally invalid. U.S. CONST. amend. XIV.

The Medical Malpractice Act is not social legislation in the constitutional sense. Rather, it is unconstitutional special interest class legislation. *Fountain Park Co. v. Hensler*, 199 Ind. 95, 155 N.E. 465, 466, 50 A.L.R. 1518 (1927).

The United States Supreme Court has stated in a general way that the guaranty of the equal protection of the laws forbids that one class should by law be compelled to suffer losses that others may gain. *Carson v. Maurer*, 424 A.2d 825, 80 A.L.R.3rd 583 (N.H. 1980); *Covington and Lexington Turnpike Road Co. v. Sanford*, 164 U.S. 578, 41 L.Ed. 560, 17 S.Ct. 198 (1896); *Reagan v. Farmers Loan & Trust Co.*, 154 U.S. 420, 38 L.Ed. 1031, 14 S.Ct. 1062 (1894). It is not constitutional to hedge the right to redress for health care related grievances with conditions both onerous and expensive. The time consuming procedures created specifically to benefit health care providers, in a way that other wrongdoers and tort feasors do not enjoy, violates the equality provision of the Constitution. U.S.

CONST. amend. XIV; 16 Am.Jr.2d *Constitutional Law* § 786; *McErlain v. Taylor*, 207 Ind. 240, 192 N.E. 260, 94 A.L.R. 1284 (1934).

The defendant physician repeatedly makes the point that plaintiff does not have a vested right in any form of action known at common law, or to any particular code of procedure. The extent to which this may be true need not be reached to decide this case. What is here involved is a deliberate attempt by the health care lobby to construct a procedure so complex, elaborate, expensive, and time consuming that it effectively deprives all but the most patient, determined, affluent, and resolute malpractice victim of access to the court room. The United States Constitution condemns such procedure. The victim is entitled to a procedure that makes a serious and determined effort to provide him with an accessible forum for the redress of his grievances. For these reasons both the Pennsylvania and Florida Courts have declared their malpractice acts unconstitutional. *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980); *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980).

How a state writes its law establishing a pretrial screening mechanism for medical malpractice claims determines whether that statute will hold up in court. Missouri's statute did not; it was ruled unconstitutional in a 5-2 decision by the State's Supreme Court.

Missouri's law failed the constitutionality test, the court said, because claimants are required to first refer claims to the Professional Liability Review Board Authority before filing their action in court. Most states with laws mandating some type of pretrial screening of malpractice claims provide for panel review *after* claims are filed in the courts. The Missouri requirement imposes a block to access to the courts, and is thus invalid, a majority of the state's high court judges said. *State ex rel. Cardinal Glennon Memorial Hospital v. Gaertner*, 583 S.W.2d 107 (Mo. 1979). Indiana's Act suffers from the same vice.

The procedural monstrosity visited upon our people by the Medical Malpractice Act cannot withstand constitutional challenge. It is procedure without legitimate purpose. Its only real function is to cause delay, make expense, and to deprive the malpractice victim of his constitutional right to "have remedy by due course of law." U.S. CONST. amend. V, VII, and XIV; *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); *Carter v. Sparkman*, 335 So.2d 802 (Fla. 1976); *American Bank & Trust Co. v. Community Hospital of Los Gotos-Saratoga, Inc.*, 163 Cal.Rptr. 513 (1980); *Graley v. Satayatham*, 343 N.E.2d 832 (Ohio 1976); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Wright v. Central Du Page Hospital Assn.*, 347 N.E.2d 736 (Ill. 1976); *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980).

CONCLUSION

This case raises basic constitutional questions regarding the power of a state legislature to establish procedural conditions precedent to access to the civil courts for redress of civil grievance. The medical malpractice "crisis" has given birth to laws similar in structure and intent throughout the several states. This is a case of first impression by the Court. The constitutional questions presented are substantial and of public importance. Probable jurisdiction should be noted, and this case should be set for argument.

Respectfully submitted,

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APPENDIX
OF
APPELLANT

APPENDIX A

Judgment of the St. Joseph Superior Court, South Bend, Indiana

We, the Jury, find for the Defendant and against the Plaintiff on her complaint.

/s/ Charles Henderson
Foreman

And now the Court, upon the request of the defendant, enters judgment for the defendant and against the plaintiff upon her complaint upon the finding of the jury.

IT IS THEREFORE, CONSIDERED, ORDERED, ADJUDGED AND DECREED by the Court, pursuant to the verdict of the jury, that the plaintiff take nothing by reason of her complaint.

Judgment.

APPENDIX B

ATTORNEYS FOR APPELLANT:

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IN THE
COURT OF APPEALS OF INDIANA
FOURTH DISTRICT

MARY C. KRANDA,	)	
	)	
Appellant (Plaintiff Below),	)	
	)	
vs.	)	No. 3-480 A 107
	)	Filed May 5, 1981
HOUSER-NORBORG MEDICAL CORPORATION and KEIM T. HOUSER, M.D.,	)	
	)	
Appellees (Defendants Below).	)	

APPEAL FROM THE ST. JOSEPH SUPERIOR COURT
The Honorable S.J. Crumpacker, Judge
Cause No. K-1967

YOUNG, P.J.

Mary C. Kranda, appellant-plaintiff, appeals from a negative judgment in a medical malpractice action against Houser-Norborg Medical Corporation and Dr. Keim Houser, M.D. The trial court granted judgment on the evidence as to the issue of informed consent and the issue of the defendant corporation's liability. The jury returned a verdict for Dr. Houser and judgment was entered accordingly.

On appeal, Kranda raises a number of issues for our consideration. For purposes of review, we have consolidated similar questions.

(1) Whether the trial court erred in permitting members of the review panel to testify and in admitting each individual panel members' written opinion into evidence.

(2) Whether the opinion of the Medical Review Panel should be excluded because it was rendered pursuant to the Indiana Medical Malpractice Act which Kranda contends is unconstitutional.

(3) Whether the trial court erred in refusing to admit into evidence the deposition of Dr. Roseman who testified at trial and the minutes of the Medical Review Panel meeting.

(4) Whether the trial court erred in withdrawing the issue of informed consent from the jury's consideration.

(5) Whether the trial court erred in the imposition of a "one pass rule."

(6) Whether the trial court erred in giving certain instructions and in refusing certain requested instructions.

(7) Whether the trial court erred in granting judgment on the evidence in favor of defendant Houser-Norborg Medical Corporation.

We affirm.

In October 1975 Kranda consulted Dr. Keim Houser, an

obstetrician-gynecologist employed by Norborg-Houser Medical Corporation, concerning problems she was having with vaginal warts. At this time, Dr. Houser also noted a Bartholin cyst deep within the tissue on the left side of her vagina. From Kranda's medical history, Dr. Houser knew that a similar cyst had been surgically removed from the same area in 1972 and that Kranda suffered from Crohn's disease[1] which had resulted in a number of hospitalizations.

After several attempts to treat the warts with medication, Dr. Houser recommended and scheduled the surgical removal of them. Before this surgery, Kranda developed problems with the Bartholin cyst. She consulted Dr. Norborg about this problem, who prescribed antibiotics and hot baths. When this treatment caused the cyst to fill with pus and open, Dr. Norborg stated that he would schedule removal of the cyst on the same date as her other surgery.

On January 28, 1976 Dr. Houser did a preoperative examination and discussed the possibility of removing the cyst during the surgery for the warts. At this time he did not discuss her Crohn's disease or the risks associated with it in surgery. Dr. Devetsky, Kranda's treating physician for her Crohn's disease, discussed with Dr. Houser the use of steroids and stated that he would order the necessary steroids. Neither doctor discussed the effect of steroids on the healing process with Kranda.

Surgery was performed on February 6, 1976 by Dr. Houser. During the surgery, he removed the remaining part of the Bartholin gland and the cyst. In this process, Dr. Houser brought the cyst up and did a rectal exam to determine the location of the scar tissue from the prior

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[1]Her Crohn's disease was first discovered in 1969. Crohn's disease is an inflammation of the ileum of the small bowel and large colon. As a result of this disease, Kranda had already had three feet of her intestine in the right colon removed.

surgery. He peeled the tissue away from the cyst. Dr. Houser testified that he could not see where the rectum was because of tissue fibrosis and scarring. As he was removing the cyst, he recognized a small rent (tear) in the rectal mucosa. Dr. Houser repaired this rectal laceration by sutures placed close to the rectum. That evening Dr. Houser told Kranda of the rectal entry and the repair and stated that he did not think there would be any problems.

On February 10, 1976 Kranda was released. That evening she felt gas escaping from the incision. Fecal matter escaped from a hole not present prior to surgery. The following day she saw Dr. Houser who could find no fecal matter escaping from a hole. The deep rectal sutures were still intact. on the 13th of February she again went to see Dr. Houser for the same problem. Because Dr. Houser was not in the office his father, also an obstetrician-gynecologist, saw her and upon examination recognized a fistula. He recommended heat treatment until he could consult with his son, Dr. Keim Houser. On the same day, Kranda saw her internist. In view of her underlying illness, he immediately recommended going to Chicago for repair surgery. She entered Rush-Presbyterian-St. Lukes Hospital in Chicago the next day. At St. Luke's, Dr. Roseman, a surgeon, performed a temporary colostomy which diverted the fecal matter from the rectum to promote the healing of the fistula. Following this operation, a bowel obstruction developed as a result of her Crohn's disease and part of the bowel had to be removed. She underwent another operation for an ileostomy. In January 1977 Dr. Roseman eliminated the ileostomy and made the colostomy partial. Kranda then improved; however, several days later she developed an abcess which was lanced several times before she returned to St. Luke's Hospital for a complete colostomy. Other than activation of her Crohn's disease, Kranda has had no further complications. She currently has a complete colostomy.

Appellant Kranda first claims error in the trial court

allowing two panel members to testify regarding their decisions and in admitting each penal member's written opinion because each opinion was based upon casual conversations with other physicians. Kranda refers to Indiana Code 16-9.5-9-4[2] to support her contention that the only information to be considered under this act is evidence submitted in writing by the parties. While Section 4 might leave that impression if read alone, Section 6 of the same act permits the panel to consult with medical authorities.[3] Kranda argues, however, that this langauge means only that the panel may consult treatises, journals, medical textbooks and similar medical authorities. Therefore, she contends the panel member's opinions were not formulated in accordance with the statute and members should not be able to testify or have their opinions admitted. We disagree. In construing a statute words used are to be given their usual and ordinary meaning; a court should not so construe a statute as to willfully and unnecessarily narrow its provisions. *Evansville-Vanderburgh School Corporation v. Roberts*, (1979) Ind.App., 395 N.E.2d 291. To assign

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[2]Indiana Code 16-9.5-9-4 reads in part:

> The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties and any other form of evidence allowable by the medical review panel. Depositions of parties and witnesses may be taken prior to the convening of the panel. The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in section 7 [16-9.5-9-7]. A copy of the evidence shall be sent to each member of the panel....

[3]IC 16-9.5-9-6 provides:

> The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

Kranda's meaning to the statutory term "medical authorities" would unnecessarily narrow this provision. The ordinary meaning given to "authorities" includes both written materials and individuals qualified in the field. *See e.g.* Webster's Third New International Dictionary 146 (1976). In addition, the term appears to refer to individuals when read in the context of the section which states that "[t]he panel may consult *with* medical authorities." IC 16-9.5-9-6. Ordinarily one consults *with* a person rather than a book or written materials.

Kranda further claims that these consultations are impermissible because she had no opportunity to cross-examine these consulted physicians, had no knowledge of these conversations and could not offer rebuttal evidence. However, Section 5 of the same act provides either party with the opportunity to convene the panel and question members concerning any matters relevant to the issues to be decided by the panel.[4] Thus, she had access to this information in her opportunity to question members as to whether and what consultations were made. She then had the opportunity to offer rebuttal evidence. Her claim is therefore without merit and the admission of testimony and the opinions were not error in this respect.

In addition, Kranda contends that these opinions are inadmissible because panel members were not advised of the law of evidence or legal standards applicable to a medical malpractice case. The record does not support this contention. Dr. Cook, one member of the panel, testified that the panel had a copy of the malpractice statute which

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[4]IC 16-19.5-9-5 provides:

> Either party, after submission of all evidence and upon ten [10] days' notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal.

the chairman went through in detai in the panel's introductory preparation. Furthermore, the statute contemplates that the panel will function in an informal and reasonable manner. *Johnson v. St. Vincents Hospital, Inc.*, (1980) Ind., 404 N.E.2d 585. The panel does not conduct a hearing or trial and does not render a decision or judgment. Rather than adjudicate the merits of the claim, its purpose is to conduct a rational inquiry into the extent and source of the patient's injuries for the purpose of forming its expert opinion. *Id.* at 596. The chairman acts in an advisory capacity only,[5] supervising the panel to assure that each party has a reasonable opportunity to present its evidence and authorities. *See, e.g. Johnson, supra.* Nothing in the record suggests that the chairman did not fulfill his duty. Furthermore, we find nothing in the statute requiring the panel to comply with the formal rules of evidence in conducting its inquiry. Therefore we cannot find the opinions inadmissible on this basis.

Kranda also argues that each individual panel member's testimony and written opinion are inadmissible because they are hearsay and are contrary to IC 16-9.5-9-7[6] and IC

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[5]IC 16-9.5-9-3 provides in part:

> The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman may establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities.

[6]IC 16-9.5-9-7 provides:

> The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty [30]

(Footnote continued on following page)

16-9.5-9-9[7] which she contends provides only for a collegial opinion. We reject the hearsay argument. First, an expert witness can draw upon all sources of information coming to his knowledge or through the results of his investigation in order to enable him to formulate an opinion. *Trinity Universal Insurance Co. v. Town of Speedway*, (1965) 137 Ind.App. 510, 210 N.E.2d 95. The fact that the expert consulted with other individuals does not render his testimony hearsay and therefore inadmissible. *Id.* In *Rosenbalm v. Winski*, (1975) 165 Ind.App. 378, 332 N.E.2d 249, this court restated the rule in *Trinity*. The hearsay "considered" must be of a type normally found reliable and customarily relied upon by the expert in the practice of his profession. *Rosenbalm, supra*. Applying the foregoing to the present case, any hearsay considered by panel members consisted of information from other doctors—a source of

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days, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

(a) The evidence supports the conclusion that defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (1) any disability and the extent and duration of the disability, and (2) any permanent impairment and the percentage of the impairment.

[7]IC 16-9.5-9-9 provides:

Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this article.

information normally found reliable and customarily relied upon by experts in the medical profession. In addition Sections 4 and 6 of the Medical Malpractice Act, referred to above, permit consultations with other doctors and also requires panel members to testify if they are called. To accept Kranda's argument would be contrary to the case law of Indiana, as well as this statutory scheme. Thus, the testimony was not inadmissible because the opinions may have been based, in part, on hearsay.

Kranda finally argues that these opinions are inadmissible because they were not in the form of a collegial opinion which she insists the statute requires. In the present case each panel member submitted his own opinion as part of the panel opinion. We cannot agree that the trial court erred in admitting these separate opinions as part of the whole opinion. Indiana Code 16-9.5-9-9 permits *any report* of the expert opinion reached by the panel to be admitted and states that such is not conclusive. Further, Kranda's contention would prevent a panel member from dissenting. The statute does not prohibit individual panel member opinions nor does it indicate that the Legislature contemplated a unanimous consensus in the opinion. In fact Section 10 of the Act[8] contemplates the possibility of not having a majority opinion. Just as this court may issue its opinion in the form of three concurring opinions, so also may the medical review panel issue its opinion in such a manner. Even assuming error in this respect, we could not determine if such was harmful error because Kranda has not provided us with these opinions to review in making this determination. For these reasons, we reject this contention.

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[8]IC 16-9.5-9-10 provides in part:

> Fees of the panel including travel expenses and other expenses of the review shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, then each side shall pay one-half [1/2] of the cost.

Kranda next argues that the Indiana Medical Malpractice Act, IC 16-9.5-1-1 *et. seq.* is unconstitutional for the following reasons:

(a) The Act has a "substantially chilling effect" on the exercise of constitutionally protected rights including the right to redress for injuries, access to the courts, and trial by jury because it requires submission of the claim to the review panel.

(b) The Act is vague to the point of being capable of an interpretation violative of constitutionally protected rights by requiring a procedure to be followed that does not provide a method of resolving legal, procedural and evidentuary disputes.

(c) The Act violates Article 1 Section 12 of the Indiana Constitution which states in pertinent part: "Justice shall be administered...speedily, and without delay." by creating a quasi-judicial procedure which results in extended delay before a case can be filed in a Court of Law and which does not provide any method of resolving the controversy.

(d) The Act violates equal protection of laws under the Fourteenth Amendment of the United States Constitution and Article 1, Section 23 of the Indiana Constitution for it creates an artificial, arbitrary, and unreasonable legislative classification between persons subjected to its provisions.

(e) The Act violates Article 7, Section 1 of the Indiana Constitution in that it constitutes an improper delegation of Judicial Power to the Indiana Department of Insurance.

(f) The monetary limitation upon a plaintiff as provided by the Act is an unwarranted violation of the plaintiff's constitutional right to trial by jury in that a jury is not permitted to assess reasonable compensation on an individual basis and the limitation on damages creates an impermissible irrebuttable presumption by depriving an injured person of the right to prove

that his individual claim is not excessive, even though it exceeds the Statutory Limitation.

(g) The Act violates the due process rights found in the United States and Indiana Constitutions by preventing a patient from recovering reasonable damages commensurate with the injury incurred.

(h) The Act violates the right to trial by Jury as guaranteed by the Seventh Amendment of the United States Constitution and Article 1, Section 20 of the Indiana Constitution by increasing the burden of proof imposed upon plaintiffs in overcoming the Medical Review Panel opinion.

(i) The Act violates the plaintiff's constitutional right to a trial by an impartial Jury, in that the Medical Review Panel is composed of fellow-doctors and colleagues of the defendant doctor; that these fellow-doctors and colleagues already benefit by the very existence of the Medical Malpractice Act; and that these fellow-doctors and colleagues also benefit directly and indirectly by a finding of no Malpractice in this case since this will serve to keep down the insurance premiums paid by the members of the Medical Review Panel as well as keep down the amount of any future judgment in any possible unrelated Malpractice actions against the Members of this Medical Review Panel.

Our Supreme Court in *Johnson, supra* has upheld the constitutionality of this Act. In Kranda's reply brief, she concedes that *Johnson, supra* is dispositive of many of these constitutional issues. However, she claims that several issues were not directly discussed in *Johnson*. Although we disagree, we will briefly address these issues separately.

Kranda first claims that the court did not address the Act's "chilling effect" on constitutionally protected rights. Kranda urges us to find that the Act has a "substantial chilling effect" on her right to redress for injuries, access to courts and trial by jury because it requires submission of

the claim to the review panel. As was noted in *Whitaker v. St. Joseph's Hospital*, (1980) Ind.App., 415 N.E.2d 737, this argument was indeed specifically rejected when our Supreme Court in *Johnson, supra* at 591-596, 604 upheld the constitutionality of the Act on this point.

Kranda next contends that the Act creates a procedure prohibitively costly in time and money without corresponding benefits. The court in *Johnson* discussed the expense and delay when it said:

> Delay in the commencement of a trial and the expense of investigating and marshalling evidence are part and parcel of the preparation of any piece of civil litigation. Delay routinely occurs between the decision to prosecute a claim and the trial. Expenses for investigation and preparation attend the pre-trial preparation of all claims. The panel submission requirement generates evidence admissible at a future trial of the claim. The delay in the trial occasioned by this process and the cost attendant to it are in major part like those to be expected in any case. The participation by the parties in the panel processes will satisfy to a great extent their preparation needs. Such satisfaction will tend to reduce total aggregate time for trial preparation. Thus, the delay complained of will be offset to an appreciable extent. The cost to the party in whose favor the opinion is rendered would be in the range that such party would expect to pay to develop such evidence individually. And the cost to the party against whom the opinion is rendered has been subjected to a cost by the process which would be much the same as he expects to pay to discover his opponent's evidence.

Johnson, supra at 592. Our Supreme Court has, therefore, upheld the procedure as not being unduly costly in time or money.

Kranda also claims that the Act creates a quasi-judicial procedure without an administrative remedy. She relied

upon a portion of the Indiana Constitution, Article 1, Section 12 which states "Justice shall be administered... speedily, and without delay." This procedure was thoroughly analyzed in *Johnson supra* at 591-596; *Whitaker, supra* at 746. Further, the right to trial is fully accorded to the plaintiff after the delay occasioned by the panel submission requirement; her remedy is provided through this adjudicative process in court. Thus, this argument is rejected.

Her contention that the Act gives judicial power to the Department of Insurance must also fail. She claims that the Act allows the Department to determine the jurisdiction of the court and that it ousts the civil courts of jurisdiction until the "medical review panel" hands down its opinion which has no force of law. Depiste assertions to the contrary the legislature has not delegated judicial power to the Indiana Department of Insurance through this Act. *Whitaker, supra,* at 746. As this court stated:

> Such power clearly resides with the courts. Neither the Indiana Department of Insurance nor the medical review panel makes an adjudication on the merits of a claim. Neither conducts a hearing or a trial and neither renders a decision or a judgment on the claims before it. The Department of Insurance is merely to advise those who inquire as to the status of the health care providers. The medical review panel is to conduct a rational inquiry into the source and extent of the patient's injury for the purpose of forming its expert medical opinion. *Johnson, supra,* at 596. These are not judicial functions.

Id. The procedure requiring filing of a proposed complaint with the Commission and submission of the claim to the panel *before* the filing of suit has been upheld in *Johnson, supra* and requires no further discussion.

Finally Kranda claims that the Act violates the separation of powers doctrine. Because the Act permits the panel opinion to be admitted into evidence, she contends

that the Legislature has usurped the courts' judicial authority to rule on the admissibility of evidence. This argument was also discussed and rejected in *Johnson, supra* at 597, 598. Additionally, she makes an argument based on hearsay which we have rejected earlier in this opinion. Therefore, this claim of a violation of the separation of powers doctrine fails as did her other constitutional attacks.

We now turn to Kranda's assignment of error relating to the trial court's refusal to admit certain items into evidence. Kranda first claims the court erred when it refused to permit the entire deposition of Dr. Roseman to be read into evidence. Dr. Roseman testified for Kranda at trial. Notwithstanding his trial testimony, Kranda argues that Roseman's deposition should have been read to the jury because the two panel members who testified considered it in formulating their opinion. The authorities cited by Kranda do not support her contention nor does the Medical Malpractice Act require or even suggest the admission of materials submitted to the panel. Therefore we must consider whether the exclusion was an abuse of discretion. A trial judge has considerable latitude in the admission or rejection of evidence. *Lovko v. Lovko*, (1978) Ind.App., 384 N.E.2d 166. Because the same facts and opinion were covered in the doctor's trial testimony, the jury already had the information before it which the panel had considered. The trial court's exclusion of the deposition was within its discretion inasmuch as the contents of it were put into evidence through the doctor's trial testimony. *See e.g. Auto-Teria, Inc. v. Ahern*, (1976) 170 Ind.App. 84, 352 N.E.2d 774; *Killion v. Updike*, (1974) 161 Ind.App. 577, 316 N.E.2d 837. Therefore the trial court committed no error in excluding the deposition.

We also find no abuse of discretion in the court refusing to admit the panel minutes. The Act does not require their admission. In addition, Kranda first offered them for evidence on recross of a defense witness. As the court

correctly noted, the minutes were beyond the scope of the redirect of the witness. The second time the minutes were offered into evidence, defense counsel objected because they were not listed in the pretrial order. While the pretrial order can be amended, *see e.g. Colonial Mortgage Co. of Indiana, Inc. v. Windmiller*, (1978) Ind.App., 376 N.E.2d 529, Kranda did not move to have it amended. The court committed no error in sustaining the objection and refusing to admit the minutes.

Kranda further argues trial court error in granting a judgment on the evidence in favor of defendants Houser and the medical corporation as to the issue of informed consent. In considering a motion for judgment on the evidence, the trial court must look only to the evidence and the reasonable inferences drawn therefrom most favorable to the nonmoving party. To sustain a TR. 50(A) judgment for a defendant, the evidence must be susceptible of but one inference in favor of the moving party and without conflict. Ind. Rules of Procedure, Trial Rule 50(A); *Stockberger v. Meridian Mut. Ins. Co.*, (1979) Ind.App., 395 N.E.2d 1272.

If reasonble persons might differ or if there is any evidence or legitimate inference to support the plaintiff's allegations, a judgment on the evidence is improper. *Id.; Huff v. Travelers Indemnity Company*, (1977) 266 Ind. 414, 363 N.E.2d 985. Such a motion "may properly be granted only if there is no substantial evidence or reasonable inference derived therefrom supporting an essential element of the claim: a complete failure of proof." *Ortho Pharmaceutical Corp. v. Chapman*, (1979) Ind.App., 388 N.E.2d 541, 544.

Kranda contends she gave no informed consent because Dr. Houser and the medical corporation failed to warn of the risk of untoward consequences. With the above standard for judgment on the evidence in mind, we must examine Kranda's evidence, if any, relating to necessary disclosures. An action prefaced on the doctrine of informed

consent is one based on negligence; therefore, the plaintiff must show (1) a duty owed to her, and (2) a breach of that duty (by falling below the set standard of care) (3) which proximately caused a compensable injury. *See e.g. Revord v. Russell*, (1980) Ind.App., 401 N.E.2d 763, at 766. Indiana recognizes the duty of a physician to make a reasonable disclosure of material facts relevant to the decision which the patient is requested to make. *Id.* (citing *Joy v. Chau*, (1978) Ind.App., 377 N.E.2d 670, 676-77).

The general rule is that expert medical testimony is required to establish the content of such "reasonable disclosure" unless the situation is clearly within the realm of laymen's comprehension as where the disclosure is so obvious that laymen could recognize the necessity of such disclosure. *Revord, supra* (citing Annot., 52 A.L.R.3rd 1084 (1973)). Experts are ordinarily indispensable to identify and elucidate for the fact finder the risks of therapy and the consequences of leaving existing maladies untreated. *Revord, supra* at 766 (quoting *Canterbury v. Spence*, (C.A.D.C. 1972) 464 F.2d 772, 786). Because Bartholin cyst surgery is not a matter within the common knowledge or experience of laymen, medical testimony was required to establish a prima facie case under informed consent. Kranda presented two medical witnesses, neither of whom were gynecologists or physicians devoting special attention to Bartholin cyst treatment. Even assuming each to have been competent to testify as to a "reasonable disclosure" for a gynecologist, neither testified that a "reasonable disclosure" would include the risk of injury to the rectum. In fact all medical testimony indicated that such an injury would not be expected. All expert witnesses, including defendant Houser, testified that they had never seen the rectum entered in this type of surgery. Therefore, Kranda failed to show that even if Houser had made a full disclosure, the risk of injury actually suffered (entering the rectum and resulting fistula) should have been among the risks disclosed.

Kranda did testify that had she known this risk (of cutting the rectum), she would not have submitted to the treatment. However, there is no evidence that revelation of any other risk would have changed her consent. Thus, the only evidence that she would have foregone the treatment was based upon a risk which defendant had no duty to disclose. Because proximate cause is a necessary element in any tort case, there must be a causal relationship between the physician's failure to inform and the injury to plaintiff. *Revord, supra.* There is no proximate cause if the plaintiff would have submitted to the treatment even if full disclosure had been made. *Revord, supra* (citing *Natanson v. Kline*, (1960) 186 Kan. 393, 350 P.2d 1093, modified, 187 Kan. 186, 354 P.2d 670). Because there is no evidence that any risk, other than cutting the rectum, would have negated her consent and because that risk was not established as one which the doctor had a duty to disclose, Kranda has failed to establish that she would not have consented if a full disclosure had been given. Therefore, the judgment on the evidence was proper because there is no evidence to support the element of proximate cause.

Kranda next contends that Local Rule 7(C) of the Rules of the St. Joseph Superior Court[9] regarding jury selection is an abuse of discretion. The right of a civil litigant to peremptory challenges is granted by Ind. Code 34-1-20-7. However, a trial court, in the exercise of its discretion, may

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[9]Local Rule 7(C) of the St. Joseph Superior Court reads in part:

> "Where counsel conduct some portion of the examination, counsel for each party may examine the panel once without passing. Counsel may be permitted to reopen the examination of passed jurors, on motion, in the discretion of the Court. Counsel shall reserve preemptory (sic.) challenges until all counsel have examined the panel once. All counsel shall then approach the bench and make their challenges in the manner and sequences that the Judge directs, and shall then pass. Jurors who are not thus excused will be deemed accepted by all parties and may not be examined further by counsel without leave of Court."

to some extent direct the manner of conducting the impanelling of juries and the manner of exercising the right of peremptory challenges. *Cochran v. State*, (1978) 269 Ind. 157, 378 N.E.2d 868. Reasonable limitations on such right may be fixed so long as the right of challenge is not taken away, and reasonable opportunity is given to challenge. *Lund v. State*, (1976) 264 Ind. 428, 345 N.E.2d 826; *Veach v. McDowell*, (1962) 133 Ind.App. 628, 184 N.E.2d 149. Local rule 7(C) permits counsel for each party to examine the panel once "without passing"[10]. Each counsel reserves peremptory challenges until all counsel have examined the panel once. When the party is required to exercise his challenges, he has heard the examination by his opponent and has had an opportunity to conduct his own examination. As was noted in *Wasy v. State*, (1955) 234 Ind. 52, 123 N.E.2d 462, a party then has at hand all the requisite information for making an intelligent choice of whether to challenge those before him. Thus the rule itself is proper.

We have no record of the voir dire examination of the jury or objections made, therefore, we are unable to make a determination as to whether or not the court property applied the rule. Appellant has the duty to bring a record which supports his claimed errors and which is sufficient to permit an intelligent decision of the issues. Ind. Rules A.P. 7.2 (A)(2); *Anderson v. Indiana State Emp. Appeals Commission*, (1977) 172 Ind.App. 529, 360 N.E.2d 1040. Thus the issue of whether the rule was properly applied is waived.

Kranda challenges several instructions given by the trial court. The trial court gave the following instruction over objection:

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[10]From the context of the rule, "without passing" appears to be used in this paragraph to mean "without accepting." Thus, counsel can pass the jury once to the opponent for examination without exercising any peremptory challenges.

> "You are instructed that expert testimony is necessary in this case to establish the standard of care to be exercised by physicians and surgeons. In determining what the standard of care was in the treatment rendered, you will be guided solely by the experts who have testified on the subject and you may not define a standard of care of your own."

A similar instruction was accepted in *Davis v. Schneider*, (1979) Ind.App., 395 N.E.2d 283. See, also *Long v. Johnson*, (1978) Ind.App., 381 N.E.2d 93. Kranda argues that such an instruction misleads the jury because it gives the impression that the panel member's opinion in conclusive. No such impression exists. The instruction was given to instruct the jury concerning the establishment of an appropriate standard of care owed by Houser to Kranda. The instruction is sufficiently clear and we do not believe that it would have misled the jury into believing the only experts to consider in determining this standard were the panel members. The general rule in malpractice cases is that, in determining whether the physician and surgeon have exercised ordinary skill and care in the diagnosis of the disease, the treatment of the patient, and the result obtained thereby, the jury must be guided solely by the testimony of physicians and surgeons because of the scientific nature and character of the questions usually involved in such cases. The jury cannot set up standard of skill and care of its own. *Davis, supra* at 288 (quoting *Adkins v. Ropp*, (1938) 105 Ind.App. 331, 335, 14 N.E.2d 727, 729). Kranda argues further in her brief that the instruction is defective because expert evidence is not required in that the treatment warranted an inference of lack of care. Because this argument was not the same basis that she argued to the trial court; we need not address this issue. TR. 51(C); *Davis, supra.*

Kranda's next allegation of error concerning instructions arises from the court giving the following:

> In determining the weight to which the testimony of

> any expert witness is entitled, you should consider the experience of the witness in the field with respect to which he has testified, how recently he has actively practiced or participated in such field, whether he is familiar with the advanced state of medical practice in such field in the community wherein the defendants have practiced or in similar communities, whether said witness is permitted or prohibited from practicing the specialty, regarding which he testified, in hospitals in the community wherein the defendants practice or in similar communities.

In her brief, Kranda raises only two objections to this instruction which were also raised at trial. She first claims that whether or not the expert witness had experience in the field with respect to which he testified or whether he practiced in it or was faimilar with such a field should not be considered in determining the weight to be given to that testimony. We disagree. To qualify as an expert witness on a subject, the witness must have sufficient skill, knowledge or experience in that field in order for his opinion to be of any value to the jury. *Davis, supra* at 290. The jury may consider what experience or familiarity the witness has in the field about which he testified in determining the weight to be given to such testimony.

Kranda further argues that the reference in the instruction to "in such field in the community...or in similar communities" applies the "locality rule" which is not applicable to a medical specialist, in particular a Board Certified physician in obstetrics and gynecology where expert testimony suggested a national standard in this field. The "modified locality rule" is accepted as the law in Indiana. *Joy v. Chau*, (1978) Ind.App., 377 N.E.2d 670. The Supreme Court of Indiana approved an instruction applying the "modified locality" rule to physicians practicing a medical speciality in *Worster v. Caylor*, (1953) 231 Ind. 625, 110 N.E.2d 337. *Id.* The rule recently received approval in *Bassett v. Glock*, (1977) Ind.App., 368 N.E.2d 18. Further, the only expert who was not from the same

community was from Chicago. The expert testimony suggested that Chicago was a similar community as related to the practice of gynecology. Thus, even if such instruction were erroneous we do not feel that the instruction could have been the basis of the verdict. Therefore, the giving of it would be harmless error.

Kranda also challenges the following instruction:

> You are instructed in this case that if you find from a fair preponderance of the evidence that the defendants in this case exercised that degree of skill and knowledge in their treatment which was ordinarily possessed by physicians and surgeons in similar circumstances and in similar fields of speciality at the time of this incident, then the plaintiff cannot recover in this action.

She claims that this instruction is improper because it is argumentative, negative and repetitious. Although stated in the negative, it is a correct statement of the law and not argumentative. While we recognize mandatory instructions are not the best type of instructions to give a jury, cases reversing on this ground generally have more than one such instruction urging the jury *repeatedly* to return a verdict for one of the parties. See *White v. Evansville American Legion Home Ass'n*, (1965) 247 Ind. 69, 210 N.E.2d 845. In *White, supra* the court told the jury eighteen different times, in substance, that the plaintiff could not recover. In the present case, we find no other mandatory instruction. Thus, we do not have the situation in *White, supra*, where the jury could easily conclude that the trial judge is repeatedly urging them to return the verdict for the defendant.

Further, we do not find this instruction unduly repetitious with the Court's Instruction Number 4. The court's instruction is a general statement defining negligence whereas this instruction applies the law to the particular facts of this case. Even if the instruction was repetitious, this court is reluctant to reverse a judgment

solely on that ground. *Keeshin Motor Express Co. v. Glassmen*, (1942) 219 Ind. 538, 38 N.E.2d 847. We recognize the principle that unnecessary repetition may be reversible error; however, in any set of instructions there is apt to be some reiteration of the applicable rules of law. *Id.* [O]nly in exceptional cases, and particularly where from the whole record we cannot fairly say that a correct result was reached, will we attempt to reverse. *Keeshin, supra.*

Instruction Number 11 which is also raised as error reads as follows:

> You are instructed that a physician is not bound to use any particular method of treatment; if, among physicians and surgeons of ordinary skill and learning, more than one method of treatment is recognized, it is proper for a doctor to adopt any recognized method of treatment. The fact that another method of treatment existed, or that another physician would have used a different method does not establish negligence.

The chief objection appears to be that the jury was not informed that it must consider the facts and circumstances of this particular case in determining if Dr. Houser selected an appropriate method of treatment. The same objection was raised and rejected in *Joy v. Chau*, (1978) Ind.App., 377 N.E.2d 670 when it accepted a similar instruction. Kranda's second argument is that the instruction confuses the jury by pointing to one issue. It is elementary that the instructions to the jury must be viewed as a whole and construed in harmony with each other and it is not necessary for any one instruction to contain all the law applicable to the case. *Joy, supra* (citing *Evans v. Breeden*, (1975) 164 Ind.App. 558, 330 N.E.2d 116). Other instructions established the duty owed to plaintiff and the standard of care required. When construed together, the instructions adequately address the issue of negligence in making the decision concerning treatment and in performing the surgery. Additionally, the jury was

instructed that it must construe all the instructions as a whole and in harmony with each other, and that it must consider the evidence in light of the law as contained in the instructions. When these instructions are read as a whole, they do not mislead the jury.

Kranda also claims that the court's instruction defining negligence was misleading because it allowed the jury to apply it equally to the plaintiff as well as to the defendants. The instruction provides:

> Negligence is the failure to do what a reasonably careful and prudent person would have done under the same or like circumstances, or the doing of something which a reasonably careful and prudent person would not have done under the same or like circumstances; in other words, negligence is the failure to exercise reasonable and ordinary care.
>
> Reasonable and ordinary care is such care as a reasonable, careful and ordinarily prudent person would exercise under the same or similar circumstances.

We do not see how this instruction could cause the jury to consider any contributory negligence of plaintiff. It does not refer to plaintiff. When read in context with the other instructions, it is clear that the instruction is referring to the defendant's basis of liability. Without more we can find no error in the court giving this instruction.

The court's instruction defining proximate cause is claimed to be defective because it refers to proximate cause in the singular; thereby, foreclosing the jury's consideration of more than one cause. Kranda's problem is that she did not object to this instruction when it was read as a Preliminary Instruction. To permit Kranda to contest the rereading of a Preliminary Instruction after it became a Final Instruction would effectively void the statutory language of TR. 51(A) unless the evidence presented or events occurring at trial have changed the possible application of the instructions. *See, e.g. Cochrane v. Lovett*, (1975) 166 Ind.App. 684, 337 N.E.2d 565. This specific

objection was available at the time the preliminary instruction was given and was not affected by the evidence or events at trial. Therefore, this question is waived. Even if not waived we would find no error because Final Instruction Number 10 adequately covered the law of proximate cause, and that defendant's negligence need not be the sole proximate cause. Thus when read as a whole, the instructions defeat this objection.

The objection to the court's instruction number 11 was based on the unconstitutionality of the Medical Malpractice Act which has been held constitutional by our Supreme Court in *Johnson v. St. Vincent's Hospital, supra.* Therefore, we need not discuss this contention.

The court's instruction number 12 was given which was a peremptory instruction removing the issues of informed consent and liability of the medical corporation from the jury.[11] A peremptory instruction may be given when there is absence of evidence to establish one or more of the elements essential to plaintiff's right to recover. *Gibson v. Froman,* (1966) 138 Ind.App. 479, 212 N.E.2d 25. Because we have decided the issue of informed consent was properly withdrawn from the jury, this instruction as to that issue was not error. The part of the instruction concerning the medical corporation, although error, was harmless error in view of the verdict in favor of the defendant doctor and our decision that the granting of the TR. 50 motion was harmless error.

Kranda next contents that the court erred in refusing to give her tendered instructions numbered 1, 2, 3, 4, 5, 12, and 13. In considering whether any error results from refusal of a tendered instruction we must determine: (1) whether the tendered instruction correctly states the law; (2) whether there is evidence in the record to support the

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[11]The objections to this instruction were the same as those considered in determining the propriety of withdrawing these issues from the jury and, therefore, are discussed fully elsewhere in this opinion.

giving of the instruction; (3) whether the substance of the tendered instruction is covered by other instructions which are given. *Dahlberg v. Ogle*, (1978) Ind., 373 N.E.2d 165 (quoting *Davis v. State*, (1976) 265 Ind. 476, 355 N.E.2d 836).

Kranda's tendered instruction number 1 outlined Houser's duty to use reasonable skill and diligence ordinarily exercised by other members of Houser's profession. The substance of this instruction was specifically set forth in Final Instructions numbered 2, 3, and 6. It is not error to refuse an instruction if the substance is covered by other instructions which are given. *Dahlberg v. Ogle, supra.*

Kranda tendered an instruction on res ipsa loquitur which, although a correct statement of the law, was refused because evidence of specific acts of negligence were presented. Presentation of evidence of specific acts of negligence is no longer recognized as a valid basis for removal of the doctrine of res ipsa loquitur from a lawsuit. *New York, Chicago & St. Louis R. Co. v. Henderson*, (1957) 237 Ind. 456, 147 N.E.2d 237. However, we must affirm a trial court's action if there is any legal ground upon the record for affirmance, even if the reason given by the trial court is erroneous. *Elmore v. City of Sullivan*, (1978) Ind.App., 380 N.E.2d 108. Thus we must determine if there was a proper ground for rejecting this instruction.

In *Carpenter v. Campbell*, (1971) 149 Ind.App. 189, 271 N.E.2d 163 this court discussed the use of this doctrine in a medical malpractice case:

> As a general proposition it may be stated that the doctrine of res ipsa loquitur permits negligence to be inferred from the unusual character of an injury suffered when it occurs while a patient and his actions or reactions are under a doctor's care and exclusive control. For the doctrine to be applicable, the injury must be of a character which would not occur but for

> an act of negligence and it must be caused by an agency or instrumentality within the exclusive control of the physician. In the last analysis, res ipsa loquitur is an evidentiary doctrine—a mere method of proof. It is premised upon an assumption that in certain instances an occurrence is so unusual that absent a reasonable justification those in control of the situation should be held responsible.

The doctrine may be invoked in medical malpractice actions when a layman is able to say that as a matter of common knowledge the consequences of the professional treatment are not those which ordinarily result if due care is exercised when there is no basis of common knowledge for such a conclusion, application of the doctrine may be grounded upon expert testimony. *Id.* at 271 N.E.2d 167. From the evidence presented, there is no question that the injury occurred while Kranda was under Dr. Houser's care and exclusive control. The issue, then, is whether the injury was of such character which would not ordinarily occur but for an act of negligence. *Brook v. St. John's Hickey Mem. Hosp.*, (1977) Ind.App., 368 N.E.2d 264 (rev'd on different grounds 269 Ind. 270, 380 N.E.2d 72). In the present case, there is no basis of common knowledge for such a conclusion; therefore, we must determine if there is expert testimony to support this conclusion.

Dr. Cook and Dr. Plain testified that in their combined seventy-five years of clinical experience they had never seen a fistula following a Bartholin gland excision. Dr. Houser stated that he had never entered the patient's rectum in thirty prior Bartholin cyst operations. In addition Dr. Roseman testified that he had not heard of a surgeon entering the rectum via the vagina. Generally, this evidence would support the conclusion that this injury is one which does not ordinarily occur. However, this evidence is defective in that no expert testified that this injury would not ordinarily occur *but for negligence*. Furthermore, no one testified that this would not

ordinarily occur in Bartholin cyst surgery on a Crohn's disease patient who had one prior surgery and resulting scar tissue. Each, in fact, testified that the situation made the surgery more complicated and more difficult. No one was familiar with a similar situation. Thus, we find no evidence to support the conclusion that the injury was one which would not ordinarily occur in the exercise of due care and the refusal of Kranda's instruction on this subject was proper.

Kranda next alleges error in the court's refusal of the following tendered instruction:

> If you find from a greater weight of the evidence that the symptoms and physical conditions existing in the plaintiff, Mary Kranda, were such as to require a careful and prudent physician and surgeon to make further investigation or more and different tests before making a diagnosis, and if you find from the evidence that the defendant, Keim T. Houser, M.D. did not make such investigations or tests, and if you further find from the evidence that as a direct and proximate result of such failure, if any, the plaintiff Mary Kranda received improper treatment from which she later suffered, then you may find the defendant Keim T. Houser, M.D. liable for all the damages and injuries suffered by the plaintiff Mary Kranda as a result of such failure.

This instruction incorrectly states the law. It would permit the jury to consider any evidence to determine if a careful and prudent physician and surgeon would have made further investigation and tests before diagnosis. A court instruction correctly stated that the only evidence to be considered on such an issue is medical expert testimony. *Davis, supra;* therefore this instruction could mislead the jury. Further, the required care must relate to physicians and surgeons who devote special attention to the ailment, its diagnosis and treatment in similar localities. *Bassett, supra.* The refusal of a defective instruction is not error.

Smith v. State, (1979) Ind., 388 N.E.2d 484. In addition, we note that the substance of this instruction was covered by other court instructions. *See, e.g. Evans v. Breeden*, (1975) 164 Ind.App. 558, 330 N.E.2d 116. Therefore, the refusal of this instruction was proper.

Kranda also tendered an instruction that if a physician or surgeon, such as Dr. Houser, knows or should know that a specialist in another field of medicine is required in order to effecuate proper treatment to the patient, it is the duty of the doctor to so advise the patient. As Kranda notes in her brief, this instruction sets out the duty of a doctor to refer a patient to a specialist when the patient's ailment is beyond the doctor's abilities. *Rahn v. United States*, (1963) 222 F.Supp. 775, 780; 35 A.L.R.3d 349. No expert testified that Dr. Houser should have referred Kranda to another doctor. Dr. Cook testified that he consults with an internist or gastroenterologist when he has a gynecology patient with Crohn's disease. While this testimony could support an instruction concerning a duty of consultation, it does not provide probative evidence of a duty of referral in this case. Therefore, the trial court did not err in refusing this instruction. Furthermore, the legal principle contained in this instruction was also covered in other court instructions given by the court. *See e.g. Evans, supra.*

Kranda argues that her tendered instructions concerning the doctor's limited liability for an occurrence of malpractice and the fact that any recovery in excess of the $100,000.00 limitation is recovered from the Patient Compensation Fund[12] should have been given in light of publicity surrounding the medical malpractice "crisis" and the extravagent claims of financial disaster made by the health care industry. While these tendered instructions are

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[12]IC 16-9.5-2-2 generally provides that a physician found negligent "is not liable for an amount in excess of $100,000.00 for an occurrence of malpractice" and that any amount in excess of $100,000.00 is recoverable from the patient's compensation fund.

correct statements of the law, they are not relevant to the issues at hand. Instructions must be relevant to the issues as formulated at trial, and this requirement is not necessarily satisfied by a correct statement of the law. *Hotz v. Gelsthorpe*, (1979) Ind.App., 387 N.E.2d 78. The purpose of instructing jurors is to advise them of a particular question they are to determine and to inform them as to the law and how to apply it to the facts as they find them to be from the evidence. *Coleman v. Chapman*, (1966) 139 Ind.App. 542, 220 N.E.2d 285. There is no question before the jury concerning the subject of these instructions. In addition, the instructions are objectionable not only because they are irrelevant but because they tend to prejudice the jury against the defendant as do other collateral sources of compensation instructions. *See, e.g. Miller v. Alvey*, (1965) 246 Ind. 560, 207 N.E.2d 633. The instruction was properly refused.

Kranda finally argues that the trial court erred in granting judgment on the evidence in favor of defendant Houser-Norborg Medical Corporation. The trial court sustained this motion on the basis that a medical corporation cannot be liable for malpractice because it cannot practice medicine. In *Birt v. St. Mary Mercy Hosp. of Gary, Inc.*, (1977) Ind.App., 370 N.E.2d 379 this court held that the corporate entity organized under the Indiana Medical Professional Corporation Act is liable for malpractice committed by one of its members. Therefore, the trial court did err in granting judgment on the evidence as to the corporation when it had also ruled that Kranda had made a prima facie case against defendant Dr. Houser. However, this error was harmless because of the jury's verdict for defendant Houser.

Kranda argues for the first time in her reply brief that the corporation's liability need not be based on vicarious liability. Rather the corporation can be liable for its own acts of negligence. Because this argument was not included

in her motion to correct errors or her original brief and because she failed to direct us to any part of the record which would support this proposition, she has waived this issue. A.R. 8.3 (A)(7); see, e.g. *Clow Corp. v. Ross Tp. School Corp.*, (1979) Ind.App., 384 N.E.2d 1077; *Highland v. Williams*, (1975) 166 Ind.App. 492, 336 N.E.2d 846; *Saloom v. Holder*, (1974) Ind.App., 307 N.E.2d 890.

The judgment of the trial court is affirmed.

MILLER, J., CONCURS.

HOFFMAN, P.J. (sitting by designation) CONCURS.

APPENDIX C
1981
CUMULATIVE SUPPLEMENT

BURNS
INDIANA STATUTES

ANNOTATED

CODE EDITION

Prepared by the Editorial Staff of the Publishers
Under the Supervision of
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TITLE 16
Articles 7-16

CHAPTER 1
DEFINITIONS AND GENERAL APPLICATIONS

SECTION.

16-9.5-1-1. Definitions.
16-9.5-1-2. Gender and number.
16-9.5-1-3. Common-law terminology.
16-9.5-1-4. Contracts in writing.
16-9.5-1-5. Qualification required for health care provider.
16-9.5-1-6. Claims—Filing complaint.
16-9.5-1-7. Prospective application.
16-9.5-1-8. Malpractice claim against a governmental entity.

16-9.5-1-1. Definitions. — As used in this article:

(a) "Health care provider" means:

(1) A person, partnership, corporation, professional corporation, facility or institution licensed or legally authorized by this state to provide health care or

professional services as a physician, psychiatric hospital, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment;

(2) Any college, university or junior college which provides health care to any student, faculty member, or employee, and the governing board, or any officer, employee or agent thereof acting in the course and scope of his employment;

(3) A blood bank, community mental health center, community mental retardation center, or community mental health clinic; or

(4) A home health agency, as defined under IC 16-10-2.5-1.

(b) "Physician" means a person with an unlimited license to practice medicine in this state under IC 25-22.5 [25-22.5-1-1.1 — 25-22.5-9-14].

(c) "Patient" means a natural person who receives or should have received health care from a licensed health care provider, under a contract, express or implied.

(d) "Hospital" means a public or private institution licensed under IC 16-10-1 [16-10-1-1 — 16-10-1-19].

(e) "Commissioner" means the commissioner of insurance of this state.

(f) "Representative" means the spouse, parent, guardian, trustee, attorney or other legal agent of the patient.

(g) "Tort" means any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

(h) "Malpractice" means any tort or breach of contract based on health care or professional services rendered, or

which should have been rendered, by a health care provider, to a patient.

(i) "Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment or confinement.

(j) "Risk manager" means an insurance company admitted to make insurance and actively engaged in making in this state class II insurance pursuant to IC 27-1-5-1, which company is appointed by the commissioner to manage the authority.

(k) "Risk" means any health care provider which shall apply for malpractice liability insurance coverage under the provisions of chapter 8 [16-9.5-8-1 — 16-9.5-8-8] of this article.

(l) "Insurer" means the authority or an insurance company engaged on an admitted or nonadmitted basis in making in this state class II (h) malpractice liability insurance pursuant to IC 27-1-5-1.

(m) "Authority" means the residual malpractice insurance authority established under chapter 8 [16-9.5-8-1 — 16-9.5-8-8] of this article.

(n) "Psychiatric hospital" means a private institution licensed under IC 16-13-2-3, and public institutions under the administrative control of the commissioner of the department of mental health as designated by IC 16-13-1-9.

(o) "Community mental health center" means any public or private mental health center established pursuant to IC 16-16-1 [16-16-1-1 — 16-16-1-10].

(p) "Community mental retardation center" means any public or private mental retardation center established pursuant to IC 16-16-1 [16-16-1-1 — 16-16-1-10].

(q) "Community mental health clinic" means any

public or private mental health clinic established pursuant to IC 16-16-3 [16-16-3-1 — 16-16-3-3].

(r) "College, university, or junior college" means any institution for post secondary school education accredited by the north central association. [IC 16-9.5-1-1, as added by Acts 1975, P.L. 146, § 1; 1976, P.L. 65, § 1; 1979, P.L. 152, § 1.]

16-9.5-1-2. Gender and number. — Whenever necessary to the context of this article [16-9.5-1-1 — 16-9.5-9-10] the masculine shall mean and include the feminine and the singular shall mean and include the plural. [IC 1971, 16-9.5-1-2, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-3. Common-law terminology. — Any legal term or word of art used in this article [16-9.5-1-1 — 16-9.5-9-10], not otherwise defined, shall have such meaning as is consistent with the common law. [IC 1971, 16-9.5-1-3, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-4. Contracts in writing. — No liability shall be imposed upon any health care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and signed by such health care provider or by an authorized agent of such health care provider. [IC 1971, 16-9.5-1-4, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-5. Qualification required for health care provider. — A health care provider who fails to qualify under this article is not covered by the provisions of this article and is subject to liability under the law without regard to the provisions of this article. If a health care provider does not so quality [qualify], the patient's remedy will not be affected by the terms and provisions of this article. [IC 1971, 16-9.5-1-5, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-6. Claims — Filing complaint. — Subject to chapter 9 [16-9.5-9-1 — 16-9.5-9-10], a patient or his representative having a claim under this article for bodily injury or death on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises. [IC 1971, 16-9.5-1-6, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-7. Prospective application. — The provisions of this article do not apply to any act of malpractice which occurred before July 1, 1975. [IC 1971, 16-9.5-1-7, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-1-8. Malpractice claim against a governmental entity. — A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental entity, as those terms are defined in IC 34-4-16.5 [34-4-16.5-1 — 34-4-16.5-18], shall be governed exclusively by the provisions of this article if the governmental entity or employee is qualified under the provisions of this article. [IC 16-9.5-1-8, as added by Acts 1976, P.L. 65, § 2, p. 287.]

CHAPTER 2

LIMITATION OF RECOVERY

SECTION.		SECTION.	
16-9.5-2-1.	Qualifications for health care provider and for the officers, agents or employees thereof.	16-9.5-2-5.	Assignability.
		16-9.5-2-6.	Proof of financial responsibility.
16-9.5-2-2.	Maximum recovery.	16-9.5-2-7.	Payment from patient's compensation fund after exhaustion of insurance coverage.
16-9.5-2-3.	Admission of liability.		
16-9.5-2-4.	Advance payments.		

16-9.5-2-1. Qualifications for health care provider and for the officers, agents or employees thereof. — (a) To be qualified under the provisions of this article, a health care provider or his insurance carrier shall:

(1) Cause to be filed with the commissioner proof of financial responsibility as provide by section 6 [16-9.5-2-6] of this chapter; and

(2) Pay the surcharge assessed by this article on all health care providers according to chapter 4 [16-9.5-4-1 — 16-9.5-4-3] of this article.

(b) The officers, agents or employees of a health care provider, while acting in the course and scope of their employment may be qualified under the provisions of this article if they are individually named, or are members of a named class, in the proof of financial responsibility filed by the health care provider under section 6 [16-9.5-2-6] of this chapter and if the surchage assessed under chapter 4 [16-9.5-4-1 — 16-9.5-4-3] of this article is paid. [IC 16-9.5-2-1, as added by Acts 1975, P.L. 146, § 1, p. 854; 1976, P.L. 65, § 3, p. 287; 1977, P.L. 187, § 2, p. 847.]

16-9.5-2-2. Maximum recovery. — (a) The total amount recoverable for any injury or death of a patient may not exceed five hundred thousand dollars [$500,000].

(b) A health care provider qualified under this article is not liable for an amount in excess of one hundred thousand dollars [$100,000] for an occurrence of malpractice.

(c) Any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers, subject to subsections (a) (and) (b), and (d) shall be paid from the patient's compensation fund pursuant to the provisions of IC 16-9.5-4-3.

(d) In the event a health care provider qualified under this article admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent or employee of the health care provider acting in the course and scope of his employment and qualified under this chapter, the total amount which shall be paid to the claimant on behalf of the officer, agent or employee and the health care provider by such health care

provider or its insurer shall be one hundred thousand dollars [$100,000] and the balance of any adjudicated sum to which the claimant is entitled, if any, shall be paid by other liable health care providers and/or the patient's compensation fund. [IC 16-9.5-2-2, as added by Acts 1975, P.L. 146, § 1, p. 854; 1976, P.L. 65, § 4, p. 287; 1977, P.L. 187, § 9, p. 847.]

16-9.5-2-3. Admission of liability. — Except as provided in chapter 4, section 3 [16-9.5-4-3], any advanced payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice. [IC 1971, 16-9.5-2-3, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-2-4. Advance payments. — Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it. [IC 1971, 16-9.5-2-4, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-2-5. Assignability. — A patient's claim for compensation under this article is not assignable. [IC 1971, 16-9.5-2-5, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-2-6. Proof of financial responability. — (a) Financial responsibility of a health care provider and its officers, agents and employees while acting in the course and scope of their employment with such health care provider under this chapter may be established:

(1) By the health care provider's insurance carrier filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars [$100,000] per occurrence, and three hundred thousand dollars [$300,000] in the annual aggregate, except that if the health care provider is a hospital, as defined in this article, the annual aggregate limit shall be: for hospitals of one hundred [100] beds or less, two million dollars [$2,000,000]; for hospitals of more than one hundred [100] beds, three million dollars [$3,000,000];

(2) By filing and maintaining with the commissioner cash or surety bond, approved by the commissioner in the amounts set forth in subdivision (1) of this subsection; or

(3) If the health care provider is a hospital, by submitting annually a verified financial statement which, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the health care provider is sufficient to satisfy all potential malpractice claims incurred by it or its officers, agents and employees while acting in the course and scope of their employment up to a total of one hundred thousand dollars [$100,000] per occurence and annual aggregates as follows: for hospitals of one hundred [100] beds or less, two million dollars [$2,000,000]; for hospitals of more than one hundred [100] beds, three million dollars [$3,000,000]. The commissioner may require the deposit of security to assure continued financial responsibility.

(b) Security provided pursuant to subdivision (2) of subsection (a) [16-9.5-2-6(a)(2)] of this section may be held in any manner, mutually agreeable to the commissioner and the health care provider. The agreement shall provide that the principal may not be withdrawn prior to receiving the written permission of the commissioner of insurance; however, any interest earned may be withdrawn at any time by the health care provider.

(c) The bed size of a hospital for the purposes of this section shall be deemed to be the bed size published annually by the Indiana state board of health.

(d) In order to establish financial responsibility under this section, each individual who is a member of a partnership or professional corporation must establish financial responsibility separate from that partnership or professional corporation, as well as pay the surcharge required under IC 16-9.5-4-1, but this provision shall not be construed to require any health care provider to "qualify" under this article. [IC 16-9.5-2-6, as added by Acts 1975, P.L. 146, § 1; 1976, P.L. 65, § 5; 1977, P.L. 187, § 3; 1979, P.L. 152, § 2.]

16-9.5-2-7. Payment from patient's compensation fund after exhaustion of insurance coverage. — In the event an annual aggregate of insurance coverage for a health care provider qualified under this article has been paid by the insurer of any such health care provider, all such sums which may thereafter become due and payable [to] a claimant arising out of an act of malpractice of such health care provider occurring during the year in which the annual aggregate of insurance coverage was exhausted shall be paid from the patient's compensation fund under the following terms and conditions:

(a) The health care provider whose annual aggregate coverage has been exhausted shall have no right to object to or refuse permission to settle any such claim.

(b) If the health care provider or the insurance commissioner and claimant agree on a settlement the following procedure must be followed:

(1) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider or, if none is pending, in the circuit or superior court of Marion County, seeking approval of the agreed settlement.

(2) A copy of the petition shall be served on the commissioner and the health care provider at least ten [10] days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the amount of the proposed settlement.

(3) The commssioner may agree to the settlment, or the commissioner may file written objections thereto. The agreement or objections shall be filed within twenty [20] days after the petition is filed.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider and the commisioner.

(5) At the hearing the commissioner, the claimant and the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commssioner and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

The commissioner may promulgate the rules and regulations implementing the provisions of this section. [IC 16-9.5-2-7, as added by Acts 1976, P.L. 65, § 6, p. 287.]

CHAPTER 3
STATUTE OF LIMITATIONS

SECTION.

16-9.5-3-1. Time for filing claim.
16-9.5-3-2. Prior actions.

IC 16-9.5-3-1. Time for filing claim. — No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or which should have been rendered unless filed within two [2] years from the date of the alleged act, omission or neglect except that a minor under the full age of six [6] years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability. [IC 1971, 16-9.5-3-1, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-3-2. Prior actions. — Notwithstanding the provisions of IC 1971, 16-9.5-1-7, any claim by a minor or other person under legal disability against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect which occurred prior to the effective date [July 1, 1975] of this article, shall be brought only within the longer of:

(a) Two [2] years of the effective date of this article; or

(b) The period described in section 1 [16-9.5-3-1] of this chapter. [IC 1971, 16-9.5-3-2, as added by Acts 1975, P.L. 146, § 1, p. 854.]

CHAPTER 4
PATIENT'S COMPENSATION FUND

SECTION.

16-9.5-4-1. Creation—Purpose—Deposit and investment—Rules and regulations.
16-9.5-4-2. Claims against fund—Procedure.
16-9.5-4-2.5. Procedure upon failure of health care provider to pay agreed settlement.
16-9.5-4-3. Excessive claims—Procedure.

16-9.5-4-1. Creation — Purpose — Deposit and

investment — Rules and regulations. — (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any income from it, shall be held in trust, deposited in a segregated account, invested and reinvested by the commissioner pursuant to IC 27-1-13 [27-1-13-1 — 27-1-13-13], and shall not become a part of the general fund of the state.

(b) To create the fund, an annual surcharge shall be levied on all health care providers in Indiana. The surcharge shall be determined by the commissioner based upon actuarial principles and shall not exceed ten percent [10%] of the cost to each health care provider for maintenance of financial responsibility.

(c) Notwithstanding subsection (b) of this section there is hereby imposed a minimum surcharge of five dollars [$5.00].

(d) The surcharge shall be collected on the same basis as premiums by each insurer, the risk manager or the surplus lines agents. Such surcharge shall be due and payable within thirty [30] days after the premium for malpractice liability insurance has been received by the insurer, risk manager or surplus lines agent from the health care provider in Indiana. If the surcharge is not paid as provided under this subsection, then the insurer, risk manager, or surplus lines agent responsible for the delinquency shall be liable for the surcharge plus a ten percent [10%] penalty.

(e) Receipt of proof of financial responsibility and the surcharge constitutes compliance with IC 16-9.5-2-1 as of the date of receipt thereof, or as of the effective date of the policy, provided this proof is filed with and the surcharge paid to the department not later than one hundred eighty [180] days after the effective date of the insurance policy. If proof of financial responsibility and the payment of the surcharge is not made within one hundred eighty [180]

days after the policy effective date, compliance occurs on the date when proof is filed and the surcharge is paid.

(f) The commissioner may promulgate rules and regulations providing for the manner in which the surcharge for health care providers establishing financial responsibility other than by a policy of malpractice liability insurance shall be determined and the manner of payment. In no event may this surcharge exceed the surcharge that would be charged by the residual authority if the health care provider electing to establish financial responsibility in this manner had applied to the residual authority for insurance.

(g) If the annual premium surcharge is not paid within the time limited above the certificate of authority of the insurer, risk manager, and surplus lines agents shall be suspended until the annual premium surcharge is paid.

(h) All expenses of collecting, protecting and administering the fund, shall be paid from the fund.

(i) If the fund exceeds the sum of fifteen million dollars [$15,000,000] at the end of any calendar year after the payment of all claims and expenses, the commissioner shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of fifteen million dollars [$15,000,000].

(j) All claims from the patient's compensation fund shall be computed on December 31 of the year in which the claims becomes final. All claims shall be paid on or before January 15. If the fund would be exhausted by payment in full of all claims allowed during a calendar year, then the amount paid to each claimant shall be prorated. Any amounts due and unpaid shall be paid in the following calendar year. [IC 16-9.5-4-1, as added by Acts 1975, P.L. 146, § 1; 1976, P.L. 65, § 7; 1979, P.L. 152, § 3.]

16-9.5-4-2. Claims against fund — Procedure. — The auditor of Indiana shall issue a warrant in the amount of

each claim submitted to him against the fund on December 31 of each year. The only claim against the fund shall be a voucher or other appropriate request by the commissioner after he receives:

(a) a certified copy of a final judgment against a health care provider; or

(b) a certified copy of a court approved settlement against a health care provider. [IC 1971, 16-9.5-4-2, as added by Acts 1975, P.L. 146, § 1, p. 854; Acts 1976, P.L. 65, § 8, p. 287.]

16-9.5-4-2.5. Procedure upon failure of health care provider to pay agreed settlement. — If a health care provider, his surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety [90] days, the same shall be paid from the patient's compensation fund, and said fund shall be subrogated to any and all of claimant's rights against said health care provider, his surety and/or liability insurance carrier with interest, reasonable costs and attorney fees. [IC 16-9.5-4-2.5, as added by Acts 1976, P.L. 65, § 9, p. 287.]

16-9.5-4-3. Excessive claims — Procedure. — If a health care provider or its insurer has agreed to settle its liability on a claim by payment of its policy limits of one hundred thousand dollars [$100,000], and claimant is demanding an amount in excess thereof, then the following procedure must be followed:

(1) A petition shall be filed by the claimant in the court named in the proposed complaint, or in the circuit or superior court of Marion County, at the claimant's election, seeking (a) approval of an agreed settlement, if any, or (b) demanding payment of damages from the patient's compensation fund.

(2) A copy of the petition with summons shall be served on the commissioner, the health care provider and his insurer, and shall contain sufficient information to inform

the other parties about the nature of the claim and the additional amount demanded.

(3) The commissioner and either the health care provider or the insurer of the health care provider may agree to a settlement with the claimant from the patient's compensation fund, or the commissioner, the health care provider or the insurer of the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after service of summons with copy of the petition attached thereto.

(4) The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing, as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the insurer of the health care provider, and the commissioner.

(5) At the hearing the commissioner, the claimant, the health care provider, and the insurer of the health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the commissioner, the health care provider, the insurer of the health care provider, and the claimant cannot agree on the amount, if any, to be paid out of the patient's compensation fund, then the court, after hearing any relevant evidence on the issue of claimant's damage, submitted by any of the parties described in this section, shall determine the amount of claimant's damages, if any, in excess of the one hundred thousand dollars [$100,000] already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient's compensation fund, the court shall consider the liability of the health care provider as admitted and established.

(6) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case tried by the court.

(7) A release executed between the parties shall not bar access to the patient's compensation fund unless the release specifically provides otherwise. [IC 16-9.5-4-3, as added by Acts 1975, P.L. 146, § 1; 1979, P.L. 152, § 4.]

CHAPTER 5

ATTORNEY FEES

SECTION.

16-9.5-5-1. Maximum fee—Fee arrangements.

16-9.5-5-1. Maximum fee — Fee arrangements. (a) When a plaintiff is represented by an attorney in the prosecution of his claim, the plaintiff's attorney fees from any award made from the patient's compensation fund may not exceed fifteen per cent [15%] of any recovery from the fund.

(b) A patient has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment. [IC 1971, 16-9.5-5-1, as added by Acts 1975, P.L. 146, § 1, p. 854.]

CHAPTER 6

REPORTING AND REVIEW OF CLAIMS

SECTION.

16-9.5-6-1. Reporting claims settled.
16-9.5-6-2. Review of provider fitness—Discipline.

16-9.5-6-1. Reporting claims settled. — All malpractice claims settled or adjudicated to final judgment against a health care provider shall be reported to the commissioner

by the plaintiff's attorney and by the health care provider or his insurer or risk manager within sixty [60] days following final disposition of the claim. The report to the commissioner shall state the following:

(a) nature of the claim;

(b) damages asserted and alleged injury;

(c) attorney's fees and expenses incurred in connection with the claim or defense; and

(d) the amount of any settlement or judgment. [IC 1971, 16-9.5-6-1, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-6-2. Review of provider fitness — Discipline. — (a) The commissioner shall foward the name of every health care provider, except a hospital, against whom a settlement is made or judgment is rendered under this article to the appropriate board of professional registration and examination for review of the fitness of the health care provider to practice his profession. In each case involving review of a health care provider's fitness to practice under this article, the board shall have the power, in appropriate cases, to take the following disciplinary action:

(1) Censure;

(2) Imposition of probation for a determinate period;

(3) Suspension of the health care provider's license for a determinate period; or

(4) Revocation of the license.

(b) Review of the health care provider's fitness to practice shall be conducted in accordance with IC 4-22-1 [4-22-1-1 — 4-22-1-30].

(c) The board shall report to the commissioner its findings, the action taken and the final disposition of each case involving review of a health care provider's fitness to practice under this article. [IC 16-9.5-6-2, as added by Acts 1975, P.L. 146, § 1, p. 854; 1977, P.L. 187, § 1, p. 847.]

CHAPTER 7

MALPRACTICE COVERAGE

SECTION.		SECTION.	
16-9.5-7-1.	Duration of coverage.	16-9.5-7-4.	Obligations—Cancellation.
16-9.5-7-2.	Insurer's acceptance.	16-9.5-7-5.	Failure of insurer to pay obligations.
16-9.5-7-3.	Void provisions.		

16-9.5-7-1. Duration of coverage. — Only while malpractice liability insurance remains in force are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this article. [IC 1971, 16-9.5-7-1, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-7-2. Insurer's acceptance. — The filing of proof of financial responsibility with the commissioner shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this article. [IC 1971, 16-9.5-7-2, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-7-3. Void provisions. — Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this article is void. [IC 1971, 16-9.5-7-3, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-7-4. Obligations — Cancellation. — Every policy issued under this article is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the general assembly of the state of Indiana as fully as if it were written therein:

(a) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this article; and

(b) Any termination of this policy by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty [30] days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the commissioner at their

offices. [IC 1971, 16-9.5-7-4, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-7-5. Failure of insurer to pay obligations. — If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails, or refuses to comply with any provisions of this article, in addition to any other legal remedy, the commissioner may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this article and has resubmitted its policy form and received the approval of the commissioner. [IC 1971, 16-9.5-7-5, as added by Acts 1975, P.L. 146, § 1, p. 854.]

CHAPTER 8

RISK MANAGEMENT—AUTHORITY

SECTION.		SECTION.	
16-9.5-8-1.	Purpose.	16-9.5-8-4.	Duties of risk manager.
16-9.5-8-2.	Residual malpractice insurance authority.	16-9.5-8-5.	Compensation of risk manager.
		16-9.5-8-6.	Declined risks—Procedure.
16-9.5-8-3.	Risk manager—Immunity to liability.	16-9.5-8-7.	Unaccepted risks—Appeal.
		16-9.5-8-8.	Investment of surplus fund.

16-9.5-8-1. Purpose. — The purpose of this chapter is to make malpractice liability insurance available to risks as defined in this article. [IC 1971, 16-9.5-8-1, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-2. Residual malpractice insurance authority. — There is created the residual malpractice insurance authority. The department of insurance is designated as the authority for the purposes of this article. The authority is empowered to engage in making Class II (h) malpractice liability insurance in this state pursuant to IC 1971, 27-1-5-1. [IC 1971, 16-9.5-8-2, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-3. Risk manager — Immunity to liability. — The commissioner shall appoint a risk manager for the authority. The separate, personal or independent assets of the risk manager shall not be liable for or subject to use or

expenditure for the purpose of providing insurance by the authority. [IC 1971, 16-9.5-8-3, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-4. Duties of risk manager. — In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(a) be subject to all laws and regulations of this state which apply to Class II (h) insurance as provided in IC 1971, 27-1-5-1;

(b) prepare and file appropriate forms with the department of insurance;

(c) prepare and file premium rates with the department of insurance;

(d) perform the underwriting function;

(e) dispose of all claims and litigations arising out of insurance policies;

(f) maintain adequate books and records;

(g) file an annual financial statement regarding its operations under this chapter with the department of insurance on forms prescribed by the commissioner;

(h) obtain private reinsurance for the authority, if necessary;

(i) prepare and file for approval of the commissioner a schedule of agent's compensation; and

(j) prepare and file a plan of operations with the commissioner for approval. [IC 1971, 16-9.5-8-4, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-5. Compensation of risk manager. — The risk manager shall receive as compensation for its services, a percentage of all premiums received by it under the terms of this chapter, as determined by the commissioner. The compensation may be adjusted by the commissioner. [IC 1971, 16-9.5-8-5, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-6. Declined risks — Procedure. — If a risk after diligent effort has been declined by at least two [2] insurers the risk may, together with evidence of the two [2] declinations, forward his application to the risk manager. [IC 1971, 16-9.5-8-6, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-7. Unaccepted risks — Appeal. — If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the applicant and the commissioner. The applicant shall have ten [10] days from the date of notice to file an appeal for review by the commissioner. On appeal, the commissioner shall review the decision of the risk manager and enter an appropriate order. [IC 1971, 16-9.5-8-7, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-8-8. Investment of surplus fund. — All sums appropriated by the state of Indiana, and any surplus of premiums over losses and expenses received by the authority shall be placed in a segregated fund and shall be invested and reinvested by the commissioner pursuant to IC 1971, 27-1-13 [27-1-13-1 — 27-1-13-13], and investment income generated shall remain in the fund. [IC 1971, 16-9.5-8-8, as added by Acts 1975, P.L. 146, § 1, p. 854.]

CHAPTER 9

MEDICAL REVIEW PANEL

SECTION.		SECTION.	
16-9.5-9-1.	Filing of proposed complaint—Tolling statute of limitations—Requests for formation of review panel.	16-9.5-9-4.	Form of evidence.
16-9.5-9-2.	Prerequisite to suit.	16-9.5-9-5.	Hearings upon issues.
16-9.5-9-3.	Composition of panel—Selection—Challenge.	16-9.5-9-6.	Examination of reports.
16-9.5-9-3.5.	Time limit for panel to render opinion—Effect of failure of party, attorney or panelist to act.	16-9.5-9-7.	Written opinion by panel.
		16-9.5-9-8.	[Repealed].
		16-9.5-9-9.	Admissibility of evidence—Witnesses—Immunity of panelist.
		16-9.5-9-10.	Compensation and fees.

16-9.5-9-1. Filing of proposed complaint — Tolling

statute of limitations —Requests for formation of review panel. — Provision is made for the establishment of medical review panels to review all proposed malpractice complaints against health care providers covered by this article.

The filing of a proposed complaint tolls the applicable statute of limitations to and including a period of ninety [90] days following the receipt of the opinion of the medical review panel by the claimant. A proposed complaint under this chapter shall be deemed filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the commissioner, who shall within ten [10] days after receipt foward by registered or certified mail a copy to each health care provider named as a defendant at his last and usual place of residence or his office.

Not earlier than twenty [20] days after the filing of a proposed complaint either party may request the formation of a medical review panel by serving a request by registered or certified mail upon all parties and the commissioner. [IC 16-9.5-9-1, as added by Acts 1975, P.L. 146, § 1, p. 854; 1977, P.L. 187, § 4, p. 847.]

16-9.5-9-2. Prerequisite to suit. — No action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this chapter and an opinion is rendered by the panel. [IC 1971, 16-9.5-9-2, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-3. Composition of panel — Selection — Challenge. — The medical review panel shall consist of one [1] attorney and three [3] health care providers. The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's

review of the proposed complaint. The chairman may establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities.

The medical review panel shall be selected in the following manner:

(a) Within fifteen [15] days after filing the request for formation of a medical review panel under section 1 [16-9.5-9-1] of this chapter, the parties shall select a panel chairman by agreement, or if no agreement can be reached, either party may request the clerk of the Supreme Court to draw at random a list of five [5] names of attorneys qualified to practice and presently on the roles of the Supreme Court and maintaining offices in the county of venue designated in the proposed complaint or in a contiguous county. The clerk shall notify the parties and the parties shall then strike names alternately with the plaintiff striking first until one [1] name remains and that remaining attorney shall be the chairman of the panel. After the striking, the plaintiff shall notify the chairman and all other parties of the name of the chairman.

If a party does not strike a name within five [5] days after notice, the clerk shall strike for that party. When one [1] name remains, the clerk shall within five [5] days notify the chairman and all other parties of the name of the chairman.

(b)(1) All health care providers in this state, whether in the teaching profession or otherwise, who hold a license to practice in their profession, shall be available for selection as members of the medical review panel.

Each party to the action shall have the right to select one [1] health care provider and upon selection, the two [2] health care providers thus selected shall select the third panelist.

When there are multiple plaintiffs or defendants, there shall be only one [1] health care provider selected per side.

The plaintiff, whether single or multiple, shall have the right to select one [1] health care provider and the defendant, whether single or multiple, shall have the right to select one [1] health care provider.

If there is only one [1] party defendant, other than a hospital, two [2] of the panelists selected shall be from the same class of health care provider as the defendant.

(2) Within fifteen [15] days after the chairman is selected, both parties shall select a health care provider and they shall notify the other party and the chairman of their selection. If a party fails to make a selection within the time provided, the chairman shall make the selection and notify both parties. Within fifteen [15] days after their selection, the health care provider members shall select the third member within the time provided and notify the chairman and the parties. If they fail to make a selection, the chairman shall make the selection and notify both parties.

(3) Within ten [10] days after any selection, written challenge without cause(,) may be made to the panel member. Upon challenge or excuse, the party whose appointee was challenged or dismissed shall select another panelist. If the challenged or dismissed panel member was selected by the other two [2] panel members, they shall make a new selection. If two [2] such challenges are made and submitted, the chairman shall within ten [10] days appoint a panel consisting of three [3] qualified panelists and each side shall within ten [10] days after the appointment strike one [1] with the party whose appointment was challenged striking last, and the remaining member shall serve.

(4) When the medical review panel is formed, the chairman shall within five [5] days notify the commissioner and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(c) A panelist selected as provided in subsection (a) or

(b) of this section shall serve unless the parties by agreement excuse him or for good cause shown he may be excused as provided in this subsection.

To show good cause for relief from serving, the attorney selected as chairman must serve an affidavit upon the clerk of the Supreme Court. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The clerk may excuse the attorney from serving and the attorney shall notify all parties who shall then select a new chairman as provided in subsection (a) of this section.

To show good cause for relief from serving, a health care provider member must serve an affidavit upon the panel chairman. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The chairman may excuse the member from serving and notify all parties. [IC 16-9.5-9-3, as added by Acts 1975, P.L. 146, § 1, p. 854; 1976, P.L. 65, § 10, p. 287; 1977, P.L. 187, § 5, p. 847.]

16-9.5-9-3.5. Time limit for panel to render opinion — Effect of failure of party, attorney or panelist to act. — (a) The panel shall render its expert opinion within one hundred eighty [180] days of the selection of the last member.

(b) A party, attorney or panelist who fails to act as required by this chapter without good cause shown is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction. [IC 16-9.5-9-3.5, as added by Acts 1976, P.L. 65, § 11, p. 287; 1977, P.L. 187, § 6, p. 847.]

16-9.5-9-4. Form of evidence. — The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only. The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties and any other form of evidence allowable

by the medical review panel. Depositions of parties and witnesses may be taken prior to the convening of the panel. The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in section 7 [16-9.5-9-7]. A copy of the evidence shall be sent to each member of the panel. [IC 1971, 16-9.5-9-4, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-5. Hearings upon issues. — Either party, after submission of all evidence and upon ten [10] days' notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal. [IC 1971, 16-9.5-9-5, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-6. Examination of reports. — The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel. [IC 1971, 16-9.5-9-6, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-7. Written opinion by panel. — The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty [30] days, render one or more of the following expert opinions which shall be in writing and signed by the panelists:

(a) The evidence supports the conclusion that defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(d) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (1) any disability and the extent and duration of the disability, and (2) any permanent impairment and the percentage of the impairment. [IC 1971, 16-9.5-9-7, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-9. Admissibility of evidence — Witnesses — Immunity of panelist. — Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this article. [IC 1971, 16-9.5-9-9, as added by Acts 1975, P.L. 146, § 1, p. 854.]

16-9.5-9-10. Compensation and fees. — Each health care provider member of the medical review panel shall be paid at the rate of twenty-five dollars [$25.00] per diem, not to exceed a total of two hundred fifty dollars [$250], for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expense.

The chairman of the panel shall be paid at the rate of one hundred dollars [$100] per diem, not to exceed five hundred dollars [$500], plus reasonable travel expenses. The chairman shall keep an accurate record of the time and expenses of all the members of the panel, and the record shall be submitted to the parties for payment with the panel's report.

Fees of the panel including travel expenses and other expenses of the review shall be paid by the side in whose favor the majority opinion is written. If there is no majority opinion, then each side shall pay one-half [½] of the cost.

The chairman shall submit a copy of the panel's report to the commissioner and all parties and attorneys by registered or certified mail within five [5] days after the panel renders its opinion. [IC 16-9.5-9-10, as added by Acts 1975, P.L. 146, § 1, p. 854; 1977, P.L. 187, § 8, p. 847.]

CHAPTER 10

PRELIMINARY DETERMINATION AND DISCOVERY

SECTION.		SECTION.	
16-9.5-10-1.	Preliminary determination and discovery authorized.	16-9.5-10-3.	Response—Hearing—Ruling.
16-9.5-10-2.	Jurisdiction—Notice.	16-9.5-10-4.	Stay pending ruling.
		16-9.5-10-5.	Enforcement.

16-9.5-10-1. Preliminary determination and discovery authorized. — A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner under this article may, upon the filing of a copy of the proposed complaint and a written motion under this chapter, (1) preliminarily determine any affirmative defense or issue of law or fact that may be preliminarily determined under the Indiana rules of procedure; or (2) compel discovery in accordance with the Indiana rules of procedure; or (3) both. The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written opinion by the medical review panel under IC 16-9.5-9-7(a), (b) and (d). The court has jurisdiction to entertain a motion filed

under this chapter only during that period of time after a proposed complaint is filed with the commissioner under this article but before the medical review panel renders its written opinion under IC 16-9.5-9-7. The failure of any party to move for a preliminary determination or to compel discovery under this chapter before the medical review panel renders its written opinion under IC 16-9.5-9-7 shall not constitute the waiver of any affirmative defense or issue of law or fact. [IC 16-9.5-10-1, as added by Acts 1979, P.L. 152, § 5.]

16-9.5-10-2. Jurisdiction — Notice. — Any party to a proceeding commenced under this article, the commissioner or the chairman of any medical review panel, if any, may invoke the jurisdiction of the court by paying the statutory filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk. The filing of a copy of the proposed complaint and motion with the clerk shall confer jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this chapter, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney fees, or both. The moving party or his attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the commissioner, each nonmoving party to the proceedings and the chairman of the medical review panel, if any, unless the commissioner or the chairman is the moving party, together with a copy of the proposed complaint and a copy of the motion pursuant to rules 4 through 4.17 of the Indiana rules of trial procedure, IC 34-5-1-1. [IC 16-9.5-10-2, as added by Acts 1979, P.L. 152, § 5.]

16-9.5-10-3. Response — Hearing — Ruling. — Each nonmoving party to the proceeding, including the commissioner and the chairman of the medical review panel, if any, shall have a period of twenty [20] days after service, or a period of twenty-three [23] days after service if service is by mail, to appear and file and serve his written

response to the motion, unless the court, for cause shown, orders the period enlarged. The court shall enter its ruling on the motion within thirty [30] days after it is heard, or if no hearing is requested, granted or ordered, within thirty [30] days after the date on which the last written response to the motion is filed, and shall order the clerk to serve a copy of its ruling on the motion by ordinary mail on the commissioner, each party to the proceeding and the chairman of the medical review panel, if any. [IC 16-9.5-10-3, as added by Acts 1979, P.L. 152, § 5.]

16-9.5-10-4. Stay pending ruling. — Upon the filing of a copy of the proposed complaint and motion with the clerk of the court, all further proceedings before the medical review panel shall be stayed automatically until the court has entered its ruling on the motion. [IC 16-9.5-10-4, as added by Acts 1979, P.L. 152, § 5.]

16-9.5-10-5. Enforcement. — The court may enforce its ruling on any motion filed under this chapter in accordance with the Indiana rules of procedure, subject to the right of appeal. [IC 16-9.5-10-5, as added by Acts 1979, P.L. 152, § 5.]

APPENDIX D
PATIENTS COMPENSATION DIVISION
DEPARTMENT OF INSURANCE
YEAR END REPORT
December 31, 1981

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Admitted Health Care Providers

MONTH REPORTING, December, 1981

ADMITTED HEALTH CARE PROVIDERS: "MASTER FILE"

	Beginning of Month		New This Month		Cancellations		End of Month	Exp.	RENEWALS
Physicians	7,662		125		1		7,070	716	712
Dentists	2,270		31		0		2,127	174	116
Nurses	12,715		496(1 Dup)		2		13,208	0	202
Hospitals	128		0(1 Dup)		0		127	0	9
Miscellaneous	2,095		31		2		1,939	185	53
Subtotal	24,870	+	683(2 Dup)	-	5	=	24,471	1,075	1,092
Total admitted Health Care Providers as of Dec. 1981							24,471		

CERTIFICATE ONLY

	Beginning of Month		New This Month		From "C.O." to Master File		End of Month
Physicians	1,288		7		0		1,295
Dentists	334		4		0		338
Nurses	3,897		60		48		3,909
Hospitals	15		1		0		16
Miscellaneous	100		4		0		104
Subtotal	5,634	+	76	-	48	=	5,662
Total "CERTIFICATE ONLY's" as of Dec. 1981							5,662

SURCHARGE ONLY

	Beginning of Month		New This Month		From "S.O." to Master File		End of Month
Physicians	17		0		0		17
Dentists	2		0		0		2
Nurses	10		0		0		10
Hospitals	1		0		0		1
Miscellaneous	9		0		0		9
Subtotal	39	+	0	-	0	=	39
Total "SURCHARGE ONLY's" as of Dec. 1981							39

NUMBER OF COPIES MADE: 986
NUMBER OF VISITORS:

MAIL: OUTGOING
MIN. 20¢ 265

CERT: R/R 111

STATUS OF MEDICAL MALPRACTICE COMPLAINTS FILED WITH THE DEPARTMENT OF INSURANCE

CUMMULATIVE TOTAL SINCE JULY 1, 1975 to DECEMBER 31, 1981

1.	Total number of complains filed with the Department of Insurance since July 1, 1975:			1,584
2.	Current number of active cases which have requested the formation of a medical review panel:		382	
3.	Current number of active cases which have not yet requested the formation of a medical review panel:		444	
4.	Current number of cases in which a panel opinion has been rendered:		248	
5.	Current number of cases which were settled prior to the rendering of a panel opinion:		428	
6.	Current number of cases which are presently defined as "Problem Status":		82	
*7	Current number of cases which have selected all 4 panel members:	102		
8.	Current number of cases which have requested a panel but all members have not yet been selected:	280		
9.	TOTALS	382	1,584	1,584

* This figure is reflected in No. 2 above.

Twenty-nine (29) payments have been made from the Patients Compensation Fund since its inception. Of this total figure, eight (8) cases have had panel opinions rendered, the remaining twenty-one (21) cases were settled prior to the rendering of a panel opinion.

PATIENTS COMPENSATION DIVISION

STATUS OF COMPLAINTS FILED PER YEAR AS OF DECEMBER 31, 1981

YEAR	NUMBER OF COMPLAINTS FILED PER YEAR	COMPLAINTS PENDING (a)	COMPLAINTS PROGRESSING (b)	PROBLEM STATUS (c)	CLOSED (d)	PANEL OPINION
1975	1	0	0	0	1	0
1976	18	1	2	0	7	8
1977	142	5	13	4	71	49
1978	272	22	53	5	123	69
1979	319	46	70	13	113	77
1980	401	110	127	29	91	44
1981	431	260	117	31	22	1
CUMM. TOTAL:	1,584	444	382	82	428	248

(a)(b)(c)— Current active cases filed with the Patients Compensation Division.

(a) PENDING— complaint has been filed, but a request for a medical review panel has not yet been received.

(b) PROGRESSING— complaint has been filed, and a request for a medical review panel has been received. The file will remain in this stage until all members of the panel have been selected.

(c) PROBLEMS— complaint has been filed, but either a dollar amount has been referred to in the prayer, or the health care provider does not comply with the Malpractice Act, or a possible statute of limitations problem.

(d) CLOSED— complaint was filed, but it was closed prior to the rendering of a panal opinion.

(e) PANEL OPINION— complaint was filed and a medical review panel rendered an opinion.

MEDICAL MALPRACTICE PANEL OPINIONS

Total Panel Opinions rendered since the inception of the Malpractice Act:		**248**
Panel Opinions rendered in 1981:		**118**
Malpractice:	**16**	
No Malpractice:	**94**	
Material Issue of Fact:	**4**	
Variations:	**4**	
Panel Opinions rendered in 1980:		**69**
Malpractice:	**7**	
No Malpractice:	**55**	
Material Issue of Fact:	**1**	
Variations:	**6**	
Panel Opinions rendered in 1979:		**40**
Malpractice:	**6**	
No Malpractice:	**33**	
Material Issue of Fact:	**1**	

Panel Opinions rendered in 1978:		17
	Malpractice: 3	
	No Malpractice: 13	
	Variations: 1	
Panel Opinions rendered in 1977:		3
	Malpractice: 1	
	No Malpractice: 2	
Panel Opinions rendered in 1976:		1
	Malpractice: 1	
Panel Opinions rendered in 1975:		0

CALENDAR YEAR STATISTICS FOR THE PATIENTS COMPENSATION FUND

	1975	1976	1977	1978	1979	1980	1981	TOTAL
Surcharge Collected	975,708.59	2,294,261.00	2,402,310.45	2,306,934.32	2,306,546.58	2,426,958.83	2,335,927.65	15,048,647.42
Interest Earned	0	25,500.00	207,831.93	265,657.40	836,941.21	824,596.54	1,358,172.55	3,518,699.63
Sub-Total	975,708.59	2,319,761.00	2,610,142.38	2,572,591.72	3,143,487.79	3,251,555.37	3,694,100.20	18,567,347.05
Judgments Paid	0	0	0	425,000.00	2,894,500.00	3,900,000.00	1,972,500.00	9,192,000.00
TOTAL:	975,708.59	2,319,761.00	2,610,142.38	2,147,591.72	248,987.79	(648,444.63)	1,721,600.20	9,375,347.05

	9,375,347.05
Office Expenses July 1, 1975 through July 1, 1981:	221,934.62
Approximate Fund Balance as of December 31, 1981:	9,153,412.43

* Judgments are paid from the Patients Compensation Fund once a year between January 1 through 15.

MULTIPLE CLAIMS REPORT

December 31, 1981

Total number of **Physicians** with **three** or more complaints filed against them: 90

59 Physicians have 3 malpractice complaints filed against them.

20 Physicians have 4 malpractice complaints filed against them.

7 Physicians have 5 malpractice complaints filed against them.

3 Physicians have 6 malpractice complaints filed against them.

1 Physician has 8 malpractice complaints filed against him.

Total number of **Dentists** with **three** or more complaints filed against them: 6

4 Dentists have 3 malpractice complaints filed against them.

1 Dentist has 4 malpractice complaints filed against him.

1 Dentist has 5 malpractice complaints filed against him.

Total number of **Osteopaths** with **three** or more complaints filed against them: 4

1 Osteopath has 3 malpractice complaints filed against him.

1 Osteopath has 4 malpractice complaints filed against him.

1 Osteopath has 5 malpractice complaints filed against him.

1 Osteopath has 7 malpractice complaints filed against him.

Total number of Chiropractors with three or more complaints filed against them: 1

1 Chiropractor has 3 malpractice complaints filed against him.

HOSPITAL MULTIPLE CLAIMS REPORT

December 31, 1981

Total number of Hospitals with five or more complaints filed against them: 51

6 Hospitals have 5 malpractice complaints filed against them.

8 Hospitals have 6 malpractice complaints filed against them.

5 Hospitals have 7 malpractice complaints filed against them.

5 Hospitals have 8 malpractice complaints filed against them.

5 Hospitals have 9 malpractice complaints filed against them.

2 Hospitals have 10 malpractice complaints filed against them.

5 Hospitals have 11 malpractice complaints filed against them.

1 Hospital has 12 malpractice complaints filed against them.

4 Hospitals have 13 malpractice complaints filed against them.

2 Hospitals have 14 malpractice complaints filed against them.

1 Hospital has 15 malpractice complaints filed against them.

1 Hospital has 18 malpractice complaints filed against them.

1 Hospital has 20 malpractice complaints filed against them.

1 Hospital has 26 malpractice complaints filed against them.

2 Hospitals have 35 malpractice complaints filed against them.

1 Hospital has 41 malpractice complaints filed against them.

1 Hospital has 68 malpractice complaints filed against them.

1982 Patients Compensation Fund Payments

Claim 1

Date Complaint Filed with Patients Comp.:	July 3, 1979
Date of alleged Malpractice:	July 4, 1977-December 1978
Judgment Entry:	October 29, 1981
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1982
	NO PANEL OPINION RENDERED
City of Occurence:	Crown Point, IN/Lowell, IN
County:	Lake
Number of Defendants:	3
Defendants Class:	Physician
Setting:	Continual care in hospital and physician office visits.

Synopsis of Claim: July 1977 Plaintiff consulted Defendants in regard to headaches, temporary loss of vision and chest pains. Defendants diagnosed Plaintiff as having Cerebral Vasculitis with possible Temporal Arteritis. Plaintiff was then placed on a continuous treatment of steriod drugs. January 1978, Plaintiff was readmitted to hospital and a biopsy was performed. Plaintiff was then diagnosed as having temporal arteritis right side. Steriod therapy

was continued. September 1978, Plaintiff was readmitted to hospital with a diagnosis of adrenalin insufficiency. Upon discharge diagnosis of temporal arteritis with a secondary diagnosis of an old fracture of the right fifth anterior rib and abnormal electrocardiogram. Steriod therapy continued. December 1978, Plaintiff readmitted to hospital, admitting diagnosis of acute coronary insufficiency. Upon discharge plaintiff was diagnosed as having coronary insufficiency, polyarteritis, acute exacerbation, with possible liver involvement and Cushings Syndrome secondary to prolonged use of steriods with a secondary diagnosis of Type IV hyperlipoproteinemia.

Plaintiff was 53 years of age in 1978, a report made in June of 1981 by a physician not affiliated with this malpractice action, indicates that Plaintiff has the musculoskeletal system of a man possibily 75 years old, due to prolonged excess steriod therapy. Plaintiff also suffers from possible steriod damage to the optic nerve, joint pain in the hips. Plaintiff now looks 15-20 years older than his pre-steriod appearance. He looks, walks, and acts like an old man. In addition steriod therapy has as a side effect the production of depression.

The following opinions were made: (1) Deterioration of musculoskeletal system is permanent. (2) Status of his vision is very unpredictable. Cataract surgery may improve vision but not return it to pre-steriod status. (3) Joint pain will continue to worsen. (4) Appearance can only worsen. (5) Emotional problems regarding his loss of libido and "self-esteem" will continue to deteriorate.

Claim 2

Date Complaint Filed with Patients Comp.: June 13, 1980
Date of alleged Malpractice: October 14, 1978

Judgment Entry:	December 28, 1981
Insurance Company:	100,000
Patients Compensation Fund:	400,000, 300,000 Patient/ 100,000 Husband
Payment made:	January 1982
Panel Opinion:	Malpractice—2 panel members No Malpractice—1 panel member

City of Occurrence:	South Bend, IN
County:	St. Joseph
Number of Defendants:	2
Defendants Class:	Physician and Clinic
Setting:	Clinic

Synopsis of Claim: At the time of Plaintiffs injury she was 31 years of age. In June of 1978 she gave birth to her first and only son. In September of 1978 Plaintiff took her son to Defendants to receive his first immunizations. The infant received his first DPT inoculation and his first dose of Orimune, a live polio virus vaccine. In October of 1978 Plaintiff began complaining of a fever, headache, muscle tenderness and weakness. Approximately 4 days later she was unable to walk, and is now permanently paralyzed, and confined to a wheelchair. Plaintiff had never been vaccinated against polio and defendant did not make any inquiry to determine whether plaintiff had been inoculated. Plaintiff was not informed of the risk associated with the inoculation of her son to uninoculated members of the family. Plaintiffs polio infection was vaccine-related from contact with her son. The vaccine given has the well known capability to shed live virus via the fecal and oral routes of the vaccinee. Plaintiff now leads a wheelchair exisence.

Claim 3

Date Complaint Filed with Patients Comp.:	October 10, 1980
Date of Alleged Malpractice:	March 13, 1979

Judgment Entry:	December 23, 1981
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment Made:	January 1982
	NO PANEL OPINION RENDERED

City of Occurrence:	Kokomo, IN
County:	Howard
Number of Defendants:	2
Defendants Class	Physician/Hospital
Setting:	Hospital

Synopsis of Claim: In March of 1979, Plaintiff mother was admitted to hospital for the purpose of delivering her child. During the course of delivery complications arose which resulted in the child suffering from a form of cerebral palsy and possible mental retardation due to the loss of oxygen during the birthing process. The Defendant failed to take the infant by cesarean section which resulted in the loss of oxygen which in turn caused the cerebral palsy.

Claim 4

Date Complaint Filed with Patients Comp.:	April 22, 1980
Dated of alleged Malpractice:	August 19, 1978

Judgment Entry:	February 19, 1981
Insurance Company:	100,000
Patients Compensation Fund:	165,000
Payment Made:	January 1982
Panel Opinion:	NO PANEL OPINION RENDERED

City of Occurrence:	Indianapolis
County:	Marion
Number of Defendants:	2
Defendants Class:	Physician (Anesthesiology)
Setting:	Hospital

Synopsis of Claim: At the time Plaintiff injury occurred, he was 42 years of age. In August of 1978 Plaintiff was admitted into hospital emergency room suffering from an injury. Plaintiff was diagnosed and treatment was prescribed which included surgery. Defendants administered anesthetic during a ureterolithotomy operation. Defendant failed to intubate patient during surgery which caused plaintiff to suffer severe and abnormal complications which resolved in the death of Plaintiff.

Claim 5

Date Complaint Filed with Patients Comp.:	August 2, 1978
Date of alleged Malpractice:	August 4, 1976

Judgment Entry:	December 16, 1981
Insurance Company:	100,000
Patients Compensation Fund:	167,500
Payment made:	January 1982
	NO PANEL OPINION RENDERED

City of Occurrence:	Oakland City
County:	Gibson
Number of Defendants:	2
Defendants Class:	DO/Hospital
Setting:	Hospital Emergency

Synopsis of Claim: Plaintiff suffered a both bone fracture of the left forearm after falling off a roof. The plaintiff at the time of the injury was 6 years of age. Plaintiff was taken to hospital and defendant reduced the fracture and maintained the patient in a long arm cast. Approximately 48 hours later plaintiff began to have increasing pain in his left upper extremeity. The following day plaintiff was taken to hospital and defendant loosened cast. Upon opening of cast the plaintiffs hand was not moving, and pressure blisters developed

over the dorsum of the hand and fingers. Later that same day the cast was bivalved by another physician, and plaintiff had no return of function to his left upper extremeity. Plaintiff was referred to another physician and surgery was performed. Plaintiff has minimal function in his forearm. Plaintiff has had to indure numerous surgeries and hospitalizations. There is nerve damage and extensive scarring of the arm. In 1980 plaintiff is wearing a dynamic brace at night.

Claim 6

Date Complaint Filed with Patients Comp.: November 7, 1979
Date of Alleged Malpractice: October 6, 1978

Judgment Entry: November 17, 1981
Insurance Company: 100,000
Patients Compensation Fund: 115,000
Payment made: January 1982
Panel Opinion: MALPRACTICE

City of Occurrence: Columbia City
County: Whitley
Number of Defendants: 1
Defendants Class Physician/General Surgery
Setting: Hospital

Synopsis of Claim: Plaintiff was admitted into the hospital for the purpose of having a bilateral vein stripping operation on both legs. Plaintiff had problems with varicose veins for a number of years prior to surgery. Surgery was performed by defendant. The day following surgery plaintiff was having pain in her leg with decreased blood supply and numbness. A second physician was consulted and plaintiff was transferred to a second hospital. Surgery was performed and there was found to be a ligature at the takeoff of the superficial femoral artery. In addition, an additional ligature was found on a moderate sized branch profundus. After further exploration it was determined that there was no proximal superficial femoral artery above the knee. The postoperative diagnosis was avulsed proximal right superficial femoral. Corrective surgery was performed but was unsuccessful and amputation below the knee was required.

Claim 7

Date Complaint Filed with Patients Comp.: September 19, 1979
Date of Alleged Malpractice: November 21, 1977

Judgment Entry: December 28, 1981
Insurance Company: 100,000

Patients Compensation Fund:	325,000, 240,000 Minor/ 85,000 Parents
Payment Made:	January 1982
Panel Opinion:	Malpractice
City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants	2
Defendants Class:	Physician (OB/GYN)/Hospital
Setting:	Hospital

Synopsis of Claim: In November of 1977 Plaintiff was admitted to the hospital for the purpose of having her child delivered by elective cesarean section. The delivery by cesarean section was performed and Plaintiff infant was delivered 6 to 8 weeks premature. Plaintiff infant has problems with cardiac, pulmonary, allergic, language, orthopaedic, growth and developmental aspects. Plaintiff infant has experienced a developmental lag, especially in the area of language. He has been attending Crossroads Rehabilitation Center.

1981 Patients Compensation Fund Payments

Claim 1

Date Complaint Filed with Patients Comp.:	September 19, 1979
Dated of alleged Malpractice:	January, 1979
Judgment Entry:	December 1980
Insurance Company	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1981
Panel Opinion:	Malpractice
City of Occurrence:	Anderson
County:	Madison
Number of Defendants:	1
Defendants Class:	Physician; OB/GYN
Setting:	Hospital Delivery Room

Synopsis of Claim: Case involves 8-9 week premature delivery by elective Cesarean section. The physician did not accurately determine the EDC prior to the Cesarean section. The panel finds the physician negligent in determining, interpreting and applying clinical evidence available to him in establishing the EDC of the mother in delivering plaintiff premature. Injury—brain damage, lung insufficiencies, and heart insufficiencies.

Claim 2

Date Complaint Filed with Patients Comp.: June 13, 1979
Date of alleged Malpractice: July 1977

Judgment Entry: December 1980
Insurance Company: 100,000
Patients Compensation Fund: 300,000
Payment made: January 1981
NO PANEL OPINION RENDERED

City of Occurrence: Anderson
County: Madison
Number of Defendants: 1
Defendants Class: Physician (Surgeon)
Setting: Hospital Surgery

Synopsis of Claim: Plaintiff admitted to hospital for ulcerative colitis. After many complications, physician opened and explored abdomen of Plaintiff. Physician did not locate abscess. X-ray was taken and showed evidence of free air with air fluid levels in the abdomen, a "cystocath" was inserted and a large quantity of air was removed from the peritoneal cavity. The air level decreased and a yellow fluid was withdrawn. Physician did not identify the fluid. Two days later same procedure performed. Another X-ray was ordered which revealed a leak from the proximal small bowel. Physician determined the perforation occurred. Plaintiff was transferred to another hospital and under went surgery. A complete exploratory was performed and a mature abscess was removed. The patient was in a morbid state by the time she reached the second hospital and the overwhelmi[illegible] peritoneal sepsis resulted in pulmonary failure and her death.

Claim 3

Date Complaint Filed with Patients Comp.: March 7, 1979
Date of alleged Malpractice: March 1977

Judgment Entry: December 1980
Insurance Company: 100,000
Patients Compensation Fund: 400,000
Payment made: January 1981
NO PANEL OPINION RENDERED

City of Occurrence: Indianapolis, IN
County: Marion

Number of Defendants: 7
Defendants Class: 5 Physicians/2 Hospitals
Setting: Hospital

Synopsis of Claim: Plaintiff was admitted to hospital, and found to have a fever and flu-like disease. Released from hospital and 2 days later readmitted with an acute respiratory distress illness. She was suffering from Staphylococcal pneumonia. An endotracheal tube was inserted. X-rays showed she had developed a cavity abscess in her lung. She became quite cyanosed. She developed a break in the covering of her lung an a collapse of her lung occurred. Her muscles were paralyzed with a drug called Pavulon to prevent her from having spontaneous respirations against the artificial respirations of the ventilating machine. She was later found disconnected from the ventilator and she was cyanotic. The ventilator was reconnected and her heart rhythm was converted to a normal rhythm by electrical means. The drug Pavulon was discontinued and it was reported that she was beginning to respond to pain, but her condition was grave. After she had been off Pavulon for 2 days, neurologists were consulted. She was found to be unconscious and unresponsive to voice command. She had flaccidity (floppiness) of the upper and lower limbs. The diagnosis by the neurologists was that she had suffered a decorticate state, a severe damage to the brain function. She was in a state of coma and it was felt that this was the result of a severe metabolic hypoxic encephalopathy, that it was the result of her brain having been damaged for not having received an adequate oxygen amount for its needs. Approximately 2 months later she was transferred to the general ward. She gradually entered into the day to day programme. Many months later she was transferred to a Rehabilitation hospital where she remained for four months, and then was discharged to her home.

The time span involved here is March 1977 through May of 1978 when she was first admitted to the Rehabilitative Center, where she remained for four months.

Injury— Diffuse brain damage the result of a lack of oxygen to the brain, permanent major disability, 24 hour care, life expectancy within 5 to 10 years of an otherwise normal life.

Claim 4

Date Complaint Filed with Patients Comp.: March 30, 1979
Date of alleged Malpractice: March 1977

Judgment Entry: December 1980

Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1981
	NO PANEL OPINION RENDERED

City of Occurrence:	East Chicago
County:	Lake
Number of Defendants:	3
Defendants Class:	2 Physicians/Hospital
Setting:	Hospital

Synopsis of Claim: Failure to diagnosis spinal meningitis. Injury, severe brain damage and handicaps including spastic quadraplegia and epilepsy.

Claim 5

Date Complaint Filed with Patients Comp.:	January 16, 1979
Date of alleged Malpractice:	January 1977

Judgment Entry:	December 1980
Insurance Company:	100,000
Patients Compensation Fund:	300,000
Payment made:	January 1981

City of Occurrence:	Richmond
County:	Wayne
Number of Defendants:	2
Defendants Class:	Physician/Hospital
Setting:	Hospital

Synopsis of Claim: Plaintiff admitted to hospital for purpose of surgical removal of her gallbladder. Subsequent to surgery plaintiff began to experience some respiratory distress. A bronchoscopy was performed. After the bronchoscopy, defendant entered certain orders for the care and treatment of plaintiff but did not order or obtain any further blood gases nor did he cause her to be intubated and provided with ventilation. Plaintiff continued to deteriorate and was finally intubated, placed on a ventilator with 100 percent oxygen, and suffered a respiratory/cardiac arrest, becoming unresponsive and suffering severe diffuse bilateral cerebral damage. Approximately 1 month later plaintiff died.

Claim 6

Date Complaint Filed with Patients Comp.:	December 29, 1977
Date of alleged Malpractice:	December 1975

Judgment Entry:	November 1980

Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1981
Panel Opinion:	MALPRACTICE

City of Occurrence:	Marion
County:	Grant
Number of Defendants:	2
Defendants Class:	Physician, Clinic
Setting:	Clinic

Synopsis of Claim: Physician administered Formalin solution to Plaintiff in an excessive concentration and for prolonged period of time which caused destructive changes in the entire urinary system. Plaintiff now must dialyzes 3 times a week. She has ease of fatigability and weakness, and a special problem in regard to her blood access.

Claim 7

Date Complaint Filed with Patients Comp.:	September 1, 1978
Date of alleged Malpractice:	November 1976

Judgment Entry:	December 1980
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1981
	NO PANEL OPINION RENDERED

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	1
Defendants Class:	Hospital
Setting:	Hospital Room

Synopsis of Claim: Alleged staff member turned off audible alarm to monitor respiratory arrest. Brain damage to infant resulted in extensive medical expense and permanent impairment. Brain damage from lack of oxygen.

Claim 8

Date Complaint Filed with Patients Comp.:	April 26, 1979
Date of alleged Malpractice:	August 1977

Judgment Entry:	October 1980
Insurance Company:	100,000
Patients Compensation Fund:	350,000
Payment made:	January 1981
	NO PANEL OPINION RENDERED

City of Occurrence:	Evansville
County:	Posey
Number of Defendants:	1
Defendants Class:	Hospital
Setting:	Hospital Delivery Room/Anesthetic

Synopsis of Claim: Plaintiff entered hospital for the purpose of delivering her first child. During the course of the delivery of the general anesthetic, plaintiff aspirated and or vomitted stomach contents into her lungs which proximately caused her death.

Claim 9

Date Complaint Filed with Patients Comp.:	November 24, 1979
Date of alleged Malpractice:	March 1978

Judgment Entry:	December 1980
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1981
	NO PANEL OPINION RENDERED

City of Occurrence:	Mishawaka
County:	St. Joseph
Number of Defendants:	3
Defendants Class:	2 Physicians/Hospital
Setting:	Hospital Delivery Room

Synopsis of Claim: Plaintiff, Mother was admitted to the hospital for the treatment of her pregnancy. She had had a heavy weight gain throughout the pregnancy with a total weight gain of 47 lb. The patient was admitted to the obstetrical floor and attempts at Pitocin induction were begun on the evening of admission and the following morning. The monitoring and induction were stopped because the monitor was needed for another patient. Plaintiff was discharged from hospital. As a result of these acts there was an unreasonable delay in delivery of infant. Plaintiff, infant, developed seizures and was transferred to the hospital. There was evidence that the asphyzia damage of the newborn was the proximate result of a failure to promptly and adequately treat the toxemia of pregnancy. As a result of the injury the plaintiff, infant, suffers from mental and motor retardation, complicated by epileptic seizures. Permanent disability.

Claim 10

Date Complaint Filed with Patients Comp.:	January 18, 1978
Date of alleged Malpractice:	June 1977

Judgment Entry:	August 1980
Insurance Company:	100,000
Patients Compensation Fund:	200,000
Payment made:	January 1981
Panel Opinion:	MALPRACTICE

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	1
Defendants Class:	Physician
Setting:	Surgery

Synopsis of Claim: Plaintiff admitted to hospital for a bilateral salpingo-oophorectomy operation. Plaintiffs left ureter was ligated with chromic suture at the level of the iliac vessels. She lost a portion of her left ureter causing additional surgery. Left kidney had to be removed.

Class 11

Date Complaint Filed with Patients Comp.:	January 24, 1979
Date of alleged Malpractice:	February 1977

Judgment Entry:	June 1980
Insurance Company:	100,000
Patients Compensation Fund:	350,000
Payment made:	January 1981
	NO PANEL OPINION RENDERED

City of Occurrence:	Rushville
County:	Rush
Number of Defendants:	4
Defendants Class:	Physician/Hospital
Setting:	Surgery Anesthetic

Synopsis of Claim: Plaintiff admitted to hospital for a cervical cone biopsy and D & C. As a result of the biopsy the plaintiff was scheduled for a hysterectomy. The operation was performed with the anesthetic agents of sodium penothal and fluothane with nitrous oxide, oxygen and anectine. Subsequent to the administration of the anesthesia plaintiff developed hepatitis, diagnosed as having been caused by the fluothane. Plaintiff however was readmitted to hospital in an hepatic coma, she later died.

1980 Patients Compensation Fund Payments

Claim 1

Date Complaint Filed with Patients Comp.: July 27, 1978
Date of alleged Malpractice: June 29, 1977

Judgment Entry: December 28, 1979
Insurance Company: 100,000
Patients Compensation Fund: 360,000
Payment made: January 1980
NO PANEL OPINION RENDERED

City of Occurence: Kokomo, IN
County: Howard
Number of Defendants: 1
Defendants Class: D.D.S.
Setting: Office

Synopsis of Claim: Negligent in administration of premedication resulting in hypoxic brain damage, with permanent coma.

Claim 2

Date Complaint Filed with Patients Comp.: January 15, 1979
Date of alleged Malpractice: December 1977

Judgment Entry: October 25, 1979
Insurance Company: 100,000
Patients Compensation Fund: 400,000
Payment made: January 1980
NO PANEL OPINION RENDERED

City of Occurrence: Indianapolis, IN
County: Marion
Number of Defendants: 2
Defendants Class: Physician/Hospital
Setting: Hospital

Synopsis of Claim: Negligent in diagnosis and treatment resulting in development of gangrene in both lower extremities. B-K Amputation.

Claim 3

Date Complaint Filed with Patients Comp.: January 22, 1979
Date of alleged Malpractice: November 24, 1977

Judgment Entry: December 17, 1979
Insurance Company: 100,000

Patients Compensation Fund:	390,000
Payment made:	January 1980
	NO PANEL OPINION RENDERED

City of Occurrence:	Ft. Wayne, IN
County:	Allen
Number of Defendants:	1
Defendants Class:	Physician (OB/GYN)
Setting:	Hospital

Synopsis of Claim: Negligent in performance of cesarean section and follow-up care; resulting in blood loss, additional surgery and cardiac arrest. Permanent comatose state.

Claim 4

Date Complaint Filed with Patients Comp.:	July 11, 1977
Date of alleged Malpractice:	July 18, 1975

Judgment Entry:	December 20, 1979
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1980
	NO PANEL OPINION RENDERED

City of Occurrence:	Ft. Wayne
County:	Allen
Number of Defendants:	2
Defendants Class:	Physician/Corporation
Setting:	Surgery

Synopsis of Claim: Negligent in intubation causing asphyxia, resulting in permanent brain damage. Exhibited by muscular twiching, seizures, and speech impairment.

Claim 5

Date Complaint Filed with Patients Comp.:	November 22, 1978
Date of alleged Malpractice:	January 18, 1978

Judgment Entry:	November 14, 1979
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1980
	NO PANEL OPINION RENDERED

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	1
Defendants Class:	Hospital
Setting:	Hospital (Dental)

Synopsis of Claim: Anesthesia negligently administered during dental surgery resulting in Hypoxic Organic Brain Syndrome.

Claim 6

Date Complaint Filed with Patients Comp.:	September 21, 1977
Date of alleged Malpractice:	September 24, 1975

Judgment Entry:	August 30, 1979
Insurance Company:	100,000
Patients Compensation Fund:	400,000
Payment made:	January 1980
Panel Opinion:	MALPRACTICE

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	7
Defendants Class:	Physician (4) Hospital, CRNA, Corporation
Setting:	Hospital (Delivery Room)

Synopsis of Claim: Neo-Natal Asphyxia; Resulting in permanent brain damage in the nature of cerebral palsy.

Claim 7

Date Complaint Filed with Patients Comp.:	June 24, 1977
Date of alleged Malpractice:	February 23, 1977

Judgment Entry:	December 5, 1979
Insurance Company:	200,000
Patients Compensation Fund:	300,000
Payment made:	January 1980
Panel Opinion:	MALPRACTICE

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	2
Defendants Class:	Physician/Hospital
Setting:	Hospital Surgery Room

Synopsis of Claim: Surgicel left in Foramen T-9, resulting in pressure on spinal cord and permanent paralysis.

Claim 8

Date Complaint Filed with Patients Comp.: October 17, 1977
Date of alleged Malpractice: July 12, 1977

Judgment Entry: November 14, 1979
Insurance Company: 100,000
Patients Compensation Fund: 240,000
Payment made: January 1980
NO PANEL OPINION RENDERED

City of Occurrence: Kokomo
County: Howard
Number of Defendants: 1
Defendants Class: Hospital
Setting: Hospital Room

Synopsis of Claim: Negligent in administering injection resulting in permanent impairment to radial nerves and muscles of left arm.

1979 Patients Compensation Fund Payments

Claim 1

Date Complaint Filed with Patients Comp.: August 9, 1977
Date of alleged Malpractice: August 12, 1975

Judgment Entry: December 27, 1978
Insurance Company: 100,000
Patients Compensation Fund: 300,000
Payment made: January 1979
NO PANEL OPINION RENDERED

City of Occurrence: Noblesville
County: Hamilton
Number of Defendants: 4
Defendants Class: Physician/Hospital
Setting: Hospital

Synopsis of Claim: Death; failure to properly diagnose, examine and move patient to better equipped medical facility.

Claim 2

Date Complaint Filed with Patients Comp.: May 1977
Date of alleged Malpractice: April 30, 1976

Judgment Entry: August 2, 1978
Insurance Company: 100,000

Patients Compensation Fund:	100,000
Payment made:	January 1979
	NO PANEL OPINION RENDERED

City of Occurrence:	Richmond, IN
County:	Wayne
Number of Defendants:	1
Defendants Class:	Physician
Setting:	Surgery

Synopsis of Claim: Below knee amputation. Tourniquet applied so extensively timewise during foot resection resulting in permanent destruction to the tissues.

Claim 3

Date Complaint Filed with Patients Comp.:	June 30, 1977
Date of alleged Malpractice:	February 25, 1976
Judgment Entry:	December 29, 1978—Wife/ May 25, 1979—Husband
Insurance Company:	100,000
Patients Compensation Fund:	25,000—Wife/4,500—Husband
Payment made:	1979—Wife/1980 Husband
	NO PANEL OPINION RENDERED

City of Occurrence:	Indianapolis, IN
County:	Marion
Number of Defendants:	2
Defendants Class:	Physician/Hospital
Setting:	Hospital

Synopsis of Claim: Plaintiffs ureter was severed during surgery to remove ovarian cyst. Additional surgery required to correct.

- Two payments were made from the Fund in this case. The case itself was finalized in 1978. Payment to the woman who was the injured party was made in 1979, and payment to the husband was made in 1980. This was due to a divorce of plaintiffs during the course of settling the claim.

January 26, 1982

Mr. William Shaner
Department of Insurance
509 State Office Building
Indianapolis, Indiana 46204

Dear Mr. Shaner:

Enclosed is our check for $3,326.00 representing surcharges collected for the month of December, along with the corresponding Certificates of Insurance. The December reports for the Residual Malpractice Insurance Authority are also enclosed.

Sincerely,

Charles E. Guiler

INDIANA PATIENTS COMPENSATION FUND

DECEMBER 30, 1981

December Premium Processed in November	$1,513.00
December Premium Processed in December.....	2,269.00
August Premium Processed in December	10.00
January Premium Processed in December	76.00
Returned Premiums.....	(542.00)
TOTAL	$3,326.00

INDIANA
RESIDUAL MALPRACTICE INSURANCE AUTHORITY
BALANCE SHEET
DECEMBER 31, 1981

		DECEMBER 31		INCREASE
		1981	1980	(DECREASE)
ASSETS:				
U.S. Treasury Notes		$10,005,256	$9,336,875	$ 668,381
Cash		645,536	101,041	544,495
Installments Due		7,009	12,938	(5,929)
Investment Income Accrued		268,781	213,225	55,556
TOTAL ASSETS		$10,926,582	$9,664,079	$1,262,503
LIABILITIES AND UNDISTRIBUTED FUNDS:				
Loss Reserves:	Reported	1,221,310	431,000	790,310
	Unreported	3,443,208	5,042,890	(1,599,682)
		4,664,518	5,473,890	(809,372)
Loss Adjustment Expense Reserves:	Reported	294,368	142,924	151,144
	Unreported	1,550,256	689,415	860,841
		1,844,624	832,339	1,012,285
Total Reserves		6,509,142	6,306,229	202,913
Reserve for Unearned Premiums		307,004	382,122	(75,118)
Patients Compensation Fund Payable		1,806	2,283	(477)
Premiums in Process		—	—	—
TOTAL LIABILITIES		6,817,952	6,690,634	127,318
UNDISTRIBUTED FUNDS		4,108,630	2,973,445	1,135,185
TOTAL LIABILITIES AND UNDISTRIBUTED FUNDS		$10,926,582	$9,664,079	$1,262,503

INDIANA
RESIDUAL MALPRACTICE INSURANCE AUTHORITY
STATEMENT OF INCOME

	AS OF DECEMBER 31 1981	1980	INCREASE (DECREASE)
INCOME:			
Direct Premiums Written:			
MD	$ 399,079	$ 478,034	($ 78,955)
DDS	2,699	4,086	(1,337)
Other	85,973	98,533	(12,550)
Corporation	47,818	58,421	(10,603)
Hospital-Excess	71,225	79,775	(8,550)
	606,794	718,649	(112,065)
Increase (Decrease) in UPR	75,118	146,380	(71,262)
EARNED PREMIUM	681,912	865,229	($ 183,317)
Investment Income:			
U.S. Treasury Notes	960,715	708,884	251,831
Repurchase Account	51,765	72,583	(20,818)
	1,012,480	781,467	231,013
TOTAL INCOME	$1,694,392	$1,646,696	$ 47,696
EXPENSES:			
Incurred Losses	($ 646,081)	$ 519,138	($1,165,219)
Incurred Loss Adjustment Expense	1,103,620	86,523	1,017,097
Risk Manager's Fee	92,249	145,668	(53,419)
Agent's Commissions	8,800	9,918	(1,118)
Other Expenses	619	186	433
TOTAL EXPENSES	559,207	761,433	(202,226)
NET INCOME	$1,135,185	$ 855,263	($ 249,922)

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY
BOND PORTFOLIO
DECEMBER 31, 1981

DESCRIPTION		MATURITY	PAR VALUE	YIELD
U.S. Treasury Note	11 1/2%	Jan 82	$ 200,000	15.40%
U.S. Treasury Note	15	Mar 82	300,000	9.20
U.S. Treasury Note	8 5/8	Jun 82	200,000	15.20
U.S. Treasury Note	8 1/8	Aug 82	500,000	8.18
U.S. Treasury Note	7 7/8	Nov 82	500,000	7.49
U.S. Treasury Note	13 5/8	Jan 83	100,000	15.66
U.S. Treasury Note	8	Feb 83	200,000	8.00
U.S. Treasury Note	14 1/2	Apr 83	200,000	15.46
U.S. Treasury Note	7 7/8	May 83	300,000	11.23
U.S. Treasury Note	14 7/8	Jul 83	300,000	16.1[illegible]
U.S. Treasury Note	7	Nov 83	500,000	7.02
U.S. Treasury Note	7 1/4	Feb 84	500,000	7.30
U.S. Treasury Note	9 1/4	May 84	500,000	9.38
U.S. Treasury Note	13 1/4	May 84	300,000	13.34
U.S. Treasury Note	8	Feb 85	500,000	7.98
U.S. Treasury Note	14 3/8	May 85	500,000	12.19
U.S. Treasury Note	8 1/4	Aug 85	500,000	8.91
U.S. Treasury Note	11 3/4	Nov 85	200,000	12.92

U.S. Treasury Note	7	7/8	May 86	500,000	11.72
U.S. Treasury Note	13	3/4	May 86	300,000	14.56
U.S. Treasury Note	8		Aug 86	500,000	8.10
U.S. Treasury Note	9		Feb 87	500,000	8.84
U.S. Treasury Note	9		Feb 87	500,000	9.01
U.S. Treasury Note	12		May 87	500,000	10.30
U.S. Treasury Note	13	1/4	Apr 88	300,000	14.12
U.S. Treasury Note	14		Jul 88	500,000	15.07
U.S. Treasury Note	8	3/4	Nov 88	200,000	10.30
				$10,100,000	10.53%

BOND MATURITIES

	PAR VALUE	AVERAGE YIELD	AVERAGE AGE IN MONTHS
6 Mos.	$ 700,000	12.69%	3
12 Mos.	1,000,000	11.19	10
18 Mos.	800,000	12.03	16
24 Mos.	800,000	10.43	22
30 Mos.	1,300,000	9.49	28
36 Mos.	—	—	—
40 Mos.	1,700,000	10.07	42
60 Mos.	1,300,000	10.98	54
72 Mos.	1,500,000	9.38	63
Over 72	1,000,000	13.83	70
	$10,100,000	10.53%	39

POLICY COLAT & DESCRIPTION 12/31/81

ISC #	DESCRIPTION	COLAT
72990	Psychologist	2
80117	Surgery—Family Practice	5
80143	Surgery—General N.C.C.	5
80150	Surgery—Cardicvascular Disease	1
80151	Anesthesiology	26
80152	Surgery—Neurgology—Incl. Child	4
80153	Surgery—Obstetrics—Gynecology	4
80154	Surgery—Orthopedic	1
80156	Surgery—Plastic—N.C.C.	1
80167	Surgery—Gynecology	1
80210	Dentists—Oral Surgery	2
80211	Dentists—N.O.C.	6
80231	Gen. Preventative Med.—No Surg.	1
80235	Phystatry	3
80239	Family Practice—No Surgery	1
80242	General Practice—No Surgery	4
80249	Psychiatry—Including Child	1
80263	Ophthalmology—No Surgery	1
80266	Pathology—No Surgery	9
80267	Pediatrics—No Surgery	4
80268	Physicians—No Surgery—N.C.C.	1

80269	Pulmonary Diseases—No Surgery	1
80275	General Practice—Minor Surgery	2
80284	Internal Medicine—Minor Surgery	1
80410	Chiropractors	15
80420	Family Phys/Gen.—No Surgery	8
80421	Family Phys/Gen.—Minor Surgery	5
80533	Physicians—No Major Surgery	4
80534	Physicians—No Major Surgery	9
80612	Hospitals—Non-Profit-Per Bed	7
80993	Chiropodists	120
80994	Chiropodists	1
80998	Nurses	26
80999	Corporate Liability	30
84242	General Practice—No Surgery	1
84267	Pediatric—No Surgery	1
84420	Family Phys./Gen.—No Surgery	1
84421	Family Phys/Gen.—Minor Surgery	1
93215	Hospitals—Cov-Per Bed	5
	Total	321

IRMIA POLICYHOLDER COUNT

	JUNE, 1981	JULY 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE JULY 1981	AUGUST 1981 NEW BUSINESS	RENEAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE AUG. 1981
MD	128	2	8	7	—	123	3	4	2	1	123
DDS	9	—	—	—	1	9	—	—	2	—	7
OTHER	152	4	15	1	—	154	6	10	—	—	160
PART/CORP-MD	17	2	1	2	—	17	—	—	—	—	17
PART/CORP-OTHER	13	—	—	—	—	13	—	—	—	—	13
HOSPITAL	1	—	2	—	—	1	—	—	—	—	1
HOSPITAL-EXCESS	12	—	—	—	—	12	—	—	—	—	12
	332	8	26	10	1	329	9	14	4	1	333

	SEPTEMBER, 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE SEPT. 1981	OCTOBER, 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE OCT. 1981
MD	3	8	3	—	123	—	12	5	—	118
DDS	1	—	—	—	9	—	2	—	1	9
OTHER	3	8	1	—	161	3	4	—	—	163
PART/CORP-MD	—	1	—	—	17	—	2	—	—	17
PART/CORP-OTHER	—	—	—	—	13	—	1	—	—	13
HOSPITAL	—	—	—	—	1	—	0	1	—	—
HOSPITAL-EXCESS	—	—	—	—	12	—	1	—	—	12
	7	17	4	—	336	3	22	6	1	332

	NOVEMBER, 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE NOV. 1981	DECEMBER, 1982 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE DEC. 1981
MD	—	11	4	—	114	—	6	1	8	105
DDS	—	1	—	1	8	—	1	—	—	8
OTHER	2	11	—	—	165	2	18	1	1	165
PART/CORP-MD	—	2	—	—	17	—	—	—	—	17
PART/CORP-OTHER	—	—	—	—	13	1	2	—	—	14
HOSPITAL	—	—	—	—	—	—	—	—	—	—
HOSPITAL-EXCESS	—	2	—	—	12	—	—	—	—	12
	2	27	4	1	329	3	27	2	9	321

	DEC. 1980	JANUARY 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE JAN. 1981	FEBRUARY 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE FEB. 1981
MD	135	—	8	4	—	131	3	4	7	—	127
DDS	10	—	—	—	—	10	—	—	—	—	10
OTHER	140	6	28	3	—	143	1	6	—	—	144
PART/CORP-MD	17	—	2	—	—	17	—	2	1	—	16
PART/CORP-OTHER	11	3	4	2	—	12	—	1	—	—	12
HOSPITAL	1	—	—	—	—	1	—	—	—	—	1
HOSPITAL-EXCESS	12	—	3	—	—	12	—	1	—	—	12
	326	9	45	9	—	326	4	14	8	—	322

	MARCH 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE MAR. 1981	APRIL 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE APR. 1981
MD	8	3	1	1	133	—	5	4	—	129
DDS	—	5	1	—	9	1	1	—	—	9
OTHER	1	—	—	—	145	—	7	—	—	146
PART/CORP-MD	1	—	—	—	17	—	—	—	—	17
PART/CORP-OTHER	—	—	—	—	12	—	1	—	—	12
HOSPITAL	—	—	—	—	1	—	—	—	—	1
HOSPITAL-EXCESS	—	1	—	—	12	—	1	—	—	12
	10	9	2	1	329	1	15	4	—	326

	MAY 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE MAY 1981	JUNE 1981 NEW BUSINESS	RENEWAL	LAPSE CANCEL	OTHER CANCEL	IN FORCE JUNE 1981
MD	1	4	—	—	130	2	17	2	2	128
DDS	—	1	—	—	9	—	—	—	—	9
OTHER	1	7	—	—	147	5	15	—	—	152
PART/CORP-MD	—	—	—	—	17	—	3	—	—	17
PART/CORP-OTHER	1	—	—	—	13	—	—	—	—	13
HOSPITAL	—	—	—	—	2	—	—	—	—	1
HOSPITAL-EXCESS	—	—	—	—	12	—	1	—	—	12
	3	12	—	—	329	7	36	2	2	332

JULY 17

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY
CASES CLOSED OR DISPOSED AS OF 12/31/82

SPECIALITY	CLS	CASE NUMBER	STATUS	S/Y DATE	OPEN DATE	CLOSE DATE	LOSS PAYMENT	ALLOCATED EXPENSE PAYMENT	TOTAL PAYMENT	S/Y TO OPEN	S/Y TO CLOSE	S/Y TO CLOSE
Hospital	0	13-00001	D	2/76	06/76	7/76	267.00		267.00	4	1	5
	0	13-00003	D	11/75	12/76	12/76	1,000.00		1,000.00	13		13
	0	13-00005	D	11/76	03/77	3/77	83.05		83.05	4		4
	0	13-00011	D	1/78	05/78	5/79	100,000.00	1,521.40	101,521.40	4	12	16
	0	13-00001	D	12/75	06/76	9/76		169.80	169.80	6	3	9
	0	13-00005	D	1/76	11/76	1/77	750.00	520.40	1,270.40	10	2	12
	0	13-00007	D	9/76	04/77	9/77	25,000.00	678.55	25,678.55	7	5	12
	0	13-00009	D	8/75	08/77	8/81		2,915.74	2,915.74	24	48	72
	0	13-00014	D	12/75	12/77	4/78	1,500.00	1,609.82	3,109.82	24	4	28
	0	13-00015	D	11/76	01/78	8/79		3,345.00	3,345.00	14	19	33
	0	13-00016	D	7/76	02/78	8/79	5,000.00	5,487.56	10,487.56	19	18	37
	0	13-00032	D	8/76	09/78	2/79	5,000.00	190.00	5,190.00	25	5	30
	0	13-00044	D	12/76	01/79	8/81	500.00	979.00	1,479.00	25	31	56
	0	13-00047	C	1/77	03/79	12/81	3,000.00	406.00	3,406.00	26	33	59
	0	13-00061	C	4/79	08/79	9/81		2,503.33	2,503.33	4	25	29
	0	13-00070	D	1/78	01/80	9/81		810.39	810.39	24	20	44
	0	13-00084	D	7/78	09/80	1/81		269.50	269.50	26	4	30
	0	13-00094	D	1/79	01/81	5/81	3,000.00	422.25	3,422.25	24	4	28
	0	13-00111	C	6/79	06/81	7/81		286.20	286.20	24	1	25
		TOTAL		19			145,100.05	22,114.94	167,214.99	307	235	542
		AVERAGE					7,636.24	1,163.94	8,800.18	16.2	12.4	28.6
Partnership/Corporation	0	13-00004	D	7/76	02/77	6/78				7	18	25
	0	13-00008	D	4/77	11/77	11/77	1,000.00		1,000.00	7		7
	0	13-00008	D	2/76	10/76	11/78		4,293.54	4,293.54	8	25	33
	0	13-00006	D	8/76	11/76	9/80		4,826.40	4,826.40	3	46	49
	0	13-00010	D	10/76	10/77	11/77				12	1	13
	0	13-00011	D	10/75	11/77	2/78		265.99	265.99	25	3	28
	0	13-00017	D	7/77	02/78	8/79		4,274.35	4,274.35	7	18	25
	0	13-00068	D	2/77	12/79	3/81		2,776.50	2,776.50	34	15	49
		TOTAL		8			1,000.00	16,436.78	17,436.78	103	126	229
		AVERAGE					125.00	2,054.60	2,179.60	12.8	15.8	28.6

SPECIALITY	CLS	CASE NUMBER	STATUS	S/Y DATE	OPEN DATE	CLOSE DATE	LOSS PAYMENT	ALLOCATED EXPENSE PAYMENT	TOTAL PAYMENT	S/Y TO OPEN	OPEN TO CLOSE	S/Y TO CLOSE
Emergency Med.—No Maj. Surgery	3	13-00013	D	1/76	12/77	3/78	5,000.00	298.22	5,298.22	23	3	26
Physicians—No Major Surgery	0	13-00120	C	1/78	08/81	9/81		331.50	331.50	43	1	44
		13-00023	C	1/76	04/78	2/79		1,577.62	1,577.62	27	10	37
Surgery—Colon and Rectal	3	13-00008	D	11/75	04/77	8/81	15,000.00	4,630.66	19,630.66	17	52	67
Surgery—Family Practice	3	13-00014	D	9/77	09/79	9/79	500.00		500.00	24		24
Surgery—General—N.O.C.	5	13-00006	D	11/75	05/77	10/77	25,000.00		25,000.00	18	5	23
	5	13-00002	C	12/75	11/76	11/80	1,250.00	5,540.95	6,790.95	11	48	59
	5	13-00053	D	4/77	05/79	8/80		475.40	475.40	25	15	40
	5	13-00064	D	8/77	09/79	11/80		1,807.35	1,807.35	25	14	39
Surgery—Vascular	7	13-00027	D	6/76	06/78	7/78		284.52	284.52	24	1	25
Anesthesiology	5	13-00010	D	7/76	05/78	6/78	10,000.00		10,000.00	22	1	23
	5	13-00050	D	6/78	04/79	7/80	55,000.00	4,166.75	59,166.75	10	15	25
Surgery—Neurology—Incl. Child	7	13-00042	C	7/77	08/79	7/81	100,000.00	6,786.59	106,786.59	25	23	48
Surgery—Obstetrics—Gynecology	6	13-00013	D	1/79	07/79	7/79	1,000.00		1,000.00	6		6
	6	13-00065	C	11/77	09/79	11/81	1,990.00	4,909.71	6,899.71	22	26	48
	6	13-00075	D	3/78	04/80	4/81		248.95	248.95	25	12	37
Surgery—Orthopedic	7	13-00002	D	4/76	12/76	5/77	100,000.00	3,071.67	103,071.67	8	5	13
	7	13-00021	D	5/76	04/78	6/80		3,713.85	3,713.85	23	26	49
	7	13-00028	D	3/77	06/78	8/79		698.10	698.10	15	14	29
	7	13-00041	D	9/76	11/78	1/81	85,000.00	2,616.83	87,616.83	26	26	52
	7	13-00049	D	3/77	03/79	1/80		1,156.25	1,156.25	24	10	34
	7	13-00051	D	4/77	04/79	1/81	30,000.00	1,046.71	31,046.71	24	21	45
	7	13-00074	D	3/77	04/80	5/80	1,990.00	604.80	2,594.80	37	1	38
Surgery—Plastic—N.O.C.	6	13-00019	D	4/76	02/78	11/78	15,000.00	534.57	15,534.57	22	9	31
Dentists—Oral Surgery	0	13-00059	D	4/77	06/79	3/81	500.00	486.00	986.00	26	21	47
Dentists—N.O.C.	0	13-00020	D	6/79	07/81	7/81	1,401.00		1,401.00	25		25
General Practice—No Surgery	0	13-00096	D	9/77	01/81	2/81		237.40	237.40	40	1	41
Ophthalmology—No Surgery	1	13-00016	D	8/78	01/80	1/80	2,500.00		2,500.00	17		17
Pediatrics—No Surgery	1	13-00092	C	7/79	01/81	11/81		1,571.40	1,571.40	18	10	28
Physicians—No Surgery—N.O.C.	1	13-00035	D	9/76	09/78	12/78		1,696.85	1,696.85	24	3	27
Chiropractors	0	13-00009	D	12/76	02/78	2/78	2,500.00		2,500.00	14		14
Orthopedists	0	13-00012	D	5/78	03/79	12/79	1,995.00	50.00	2,045.00	10	9	19
	0	13-00017	D	1/81	03/81	3/81	900.00		900.00	2		2
	0	13-00057	D	7/77	05/79	4/81		2,962.82	2,962.82	22	23	45

SPECIALITY	CLS	CASE NUMBER	STATUS	S/Y DATE	OPEN DATE	CLOSE DATE	LOSS PAYMENT	ALLOCATED EXPENSE PAYMENT	TOTAL PAYMENT	S/Y TO OPEN	OPEN TO CLOSE	S/Y TO CLOSE
	0	13-00073	C	8/78	03/80	11/81	3,500.00	773.57	4,273.57	19	20	39
	0	13-00077	C	8/78	05/80	12/81	3,000.00	1,385.75	4,385.75	21	19	40
	0	13-00080	C	7/78	08/80	11/81		2,323.86	2,323.86	25	15	40
	0	13-00082	D	8/78	09/80	3/81	500.00	216.50	1,216.50	25	6	31
	0	13-00083	D	7/79	09/80	8/81		1,949.30	1,949.30	14	11	25
	0	13-00089	C	6/80	11/80	12/81		93.50	93.50	5	13	18
Physicians—No Major Surgery	0	13-00007	D	12/79	05/77	6/77	1,995.00		1,995.00	17	1	18
	0	13-00012	D	11/75	12/77	8/79		1,903.30	1,903.30	25	20	45
	0	13-00029	D	10/76	07/78	3/79		445.40	445.40	21	8	29
		TOTAL		43			465,521.00	61,116.65	526,637.65	896	518	1414
		AVERAGE					10,826.07	1,421.32	12,247.39	20.9	12.0	32.9
		TOTAL		70			611,621.05	99,668.37	711,289.42	1306	879	2185
		AVERAGE					8,737.44	1,423.83	10,161.28	18.7	12.6	31.3

END OF JOB

A-102

INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY
CASES PENDING AS OF 12/31/81

JULY 13

DATE 12/31/81

SPECIALTY	CLASS	CASE NUMBER	DATE OPENED	S/Y DATE	LOSS RESERVE	EXPENSE RESERVE	TOTAL RESERVE	ALLOCATED EXPENSE PAYMENT	LIFE OF S/Y TO OPEN	CASE SY TO DATE	IN MTH. OPEN TO DATE
Hospital	—	13-00020	03-72	04-76	2,000	3,013	5,013	3,614.89	23	68	35
	—	13-00036	09-78	07-77	50,000	4,225	54,225	774.90	14	53	39
	—	13-00037	10-78	09-76	35,000	8,000	43,000	—	25	63	38
	—	13-00048	03-79	07-76	7,500	4,000	11,500	—	32	65	33
	—	13-00054	05-79	06-77	2,000	1,247	3,247	753.08	23	54	31
	—	13-00085	09-80	07-78	1,500	3,700	5,200	—	26	41	15

SPECIALTY	CLASS	CASE NUMBER	DATE OPENED	S/Y DATE	LOSS RESERVE	EXPENSE RESERVE	TOTAL RESERVE	ALLOCATED EXPENSE PAYMENT	LIFE OF S/Y TO OPEN	CASE SY TO DATE	IN MTH. OPEN TO DATE
	—	13-00087	10-80	09-78	1,500	734	2,234	2,966.05	25	39	14
	—	13-00100	02-81	11-76	1,500	2,293	3,793	706.52	51	61	10
	—	13-00110	06-81	05-79	5,000	3,000	8,000	—	25	31	6
	—	13-00119	08-81	06-76	4,500	3,500	8,000	—	62	66	4
		TOTAL	10		110,500	33,712	144,212	8,815.44	306	541	235
		AVERAGE			11,050	3,371	14,421	881.54	30.6	54.1	23.5
Partnership/Corporation	—	13-00034	09-78	08-76	20,000	5,000	25,000	1,238.10	25	64	39
	—	13-00040	10-78	09-76	5,000	4,618	9,618	5,071.07	25	63	38
	—	13-00109	05-81	06-79	3,000	2,416	5,416	583.02	23	30	7
		TOTAL	3		28,000	12,034	40,034	4,892.19	73	157	84
		AVERAGE			9,333	4,011	13,344	1,630.73	24.3	52.3	38.0
Emergency Med.—No Maj. Surgery	3	13-00125	11-81	07-80	3,500	2,500	6,000	—	16	17	1
Surgery—Ophthalomology	3	13-00018	02-78	01-76	10,000	11,137	21,137	8,329.65	25	71	46
Surgery—Family Practice	3	13-00105	04-81	01-80	9,000	3,000	12,000	—	15	23	8
	3	13-00112	07-81	03-80	4,500	2,495	6,995	5.00	16	21	5
	3	13-00113	07-81	10-80	2,500	2,500	5,000	—	9	14	5
	3	13-00126	12-81	10-81	2,500	2,260	4,760	240.00	2	2	
Surgery—General—N.O.C.	5	13-00039	10-78	09-76	35,000	7,000	42,000	1,871.76	25	63	38
	5	13-00060	07-79	10-78	30,000	6,313	36,313	3,504.30	9	38	29
	5	13-00071	01-80	01-78	1,500	1,933	3,433	1,766.95	24	47	23
	5	13-00091	11-80	07-79	1,500	2,471	3,971	1,529.50	16	29	13
	5	13-00098	02-81	01-79	1,500	1,845	3,345	2,156.20	25	35	10
Surgery—Cardiovascular Disease	7	13-00086	09-80	08-78	10,000	3,998	13,998	2,641.75	25	40	15
	7	13-00090	11-80	10-78	25,000	3,575	28,575	2,271.45	25	38	13
Anesthesiology	5	13-00018	05-81	03-81	310		310	—	2	9	7
	5	13-00063	08-79	08-77	50,000	4,833	54,833	166.80	24	52	28
	5	13-00066	12-79	11-77	20,000	4,583	24,583	1,452.86	25	49	24
	5	13-00076	05-80	04-78	75,000	716CR	74,284	6,725.29	25	44	19
	5	13-00106	04-81	08-78	1,500	872	2,372	2,128.30	32	40	8
	5	13-00129	12-81	8-76	4,500	2,500	7,000	—	64	64	—

SPECIALTY	CLASS	CASE NUMBER	DATE OPENED	S/Y DATE	LOSS RESERVE	EXPENSE RESERVE	TOTAL RESERVE	ALLOCATED EXPENSE PAYMENT	LIFE OF S/Y TO OPEN	CASE SY TO DATE	IN MTH. OPEN TO DATE
Surgery—Neurology—Incl. Child	7	13-00117	08-81	03-80	5,000	3,927	8,927	572.30	17	21	4
Surgery—Obstetrics—Gynecology	6	13-00022	07-81	11-80	6,000	—	6,000	—	8	13	5
	6	13-00033	09-78	03-76	2,000	3,637	5,637	4,078.10	30	69	39
	6	13-00052	05-79	04-77	1,500	1,686	3,186	4,783.50	25	56	31
	6	13-00079	06-80	06-78	1,500	2,984	4,484	714.20	24	42	18
	6	13-00108	04-81	04-79	30,000	3,841	33,841	2,675.69	24	32	8
	6	13-00124	11-81	11-79	75,000	8,000	83,000	—	24	25	1
Surgery—Orthopedic	7	13-00003	09-76	12-75	35,000	4,509	39,509	9,082.41	9	72	63
	7	13-00024	04-78	05-76	2,000	2,009	4,009	8,912.34	23	67	44
	7	13-00025	04-78	02-76	10,000	6,000	16,000	1,077.71	26	70	44
	7	13-00031	08-78	08-76	2,000	2,500	4,500	—	24	64	40
	7	13-00045	02-79	12-76	2,500	2,000	4,500	—	26	60	34
	7	13-00072	02-80	01-78	75,000	8,829	83,829	4,694.76	25	47	22
Surgery—Plastic—N.O.C.	6	13-00069	01-80	03-77	1,500	2,473	3,973	4,713.10	34	57	23
	6	13-00104	04-81	03-79	1,500	2,181	3,681	818.20	25	33	8
Dentists—Oral Surgery	0	13-00046	02-79	06-77	8,000	5,000	13,000	1,135.55	20	54	34
Family Practice—No Surgery	0	13-00056	05-79	01-77	2,000	6,000	8,000	2,842.49	28	59	31
	0	13-00081	09-80	08-78	1,500	2,437	3,937	1,262.56	25	40	15
General Practice—No Surgery	0	13-00055	05-79	08-78	35,000	13,480	48,480	7,097.15	9	40	31
Nuclear Medicine	1	13-00038	10-78	06-76	10,000	2,406	12,406	1,094.35	28	66	38
Pediatrics—No Surgery	1	13-00087	12-79	12-77	75,000	10,000	85,000	591.58	24	48	14
	1	13-00093	01-81	01-76	90,000	10,000	100,000	—	60	71	11
General Practice—Minor Surgery	0	13-00099	02-81	08-79	35,000	5,361	40,361	3,092.10	18	28	10
	0	13-00116	08-81	08-79	4,500	3,700	8,200	300.00	24	28	4
Chiropractors	0	13-00095	01-81	03-79	1,500	3,000	4,500	—	22	33	11
Physicians—No Major Surgery	0	13-00023	08-81	05-81	500		500	—	3	7	4
Orthopedists	0	13-00019	06-81	12-80	1,500		1,500	—	6	12	6
	0	13-00021	07-81	07-80	2,500		2,500	—	12	17	5
	0	13-00026	05-78	05-77	10,000	2,000	12,000	—	12	55	43
	0	13-00043	01-75	06-78	45,000	5,188	50,188	5,941.46	7	42	35
	0	13-00058	05-79	05-77	1,500	623	2,123	4,375.88	24	53	31
	0	13-00078	06-80	02-79	90,000	8,257	98,257	1,743.41	16	34	18

SPECIALTY	CLASS	CASE NUMBER	DATE OPENED	S/Y DATE	LOSS RESERVE	EXPENSE RESERVE	TOTAL RESERVE	ALLOCATED EXPENSE PAYMENT	LIFE OF S/Y TO OPEN	CASE SY TO DATE	IN MTH. OPEN TO DATE
	0	13-00088	10-80	10-78	1,500	2,177	3,677	823.10	24	38	14
	0	13-00097	02-81	06-79	35,000	6,000	41,000	—	20	30	10
	0	13-00101	03-81	03-79	1,500	1,919	3,419	1,080.06	24	33	9
	0	13-00103	03-81	03-79	1,500	2,750	4,250	250.00	24	33	9
	0	13-00107	04-81	10-79	1,500	2,148	3,648	851.50	18	26	8
	0	13-00114	07-81	02-80	2,500	2,500	5,000	—	17	22	5
	0	13-00115	07-81	11-80	2,500	2,386	4,886	114.00	8	13	5
	0	13-00116	07-81	09-80	2,500	2,500	5,000	—	10	15	5
	0	13-00121	09-81	06-79	4,500	3,500	8,000	—	25	28	3
	0	13-00122	10-81	10-80	2,500	2,500	5,000	—	12	14	2
	0	13-00123	11-81	02-80	5,000	3,158	8,158	341.60	21	22	1
	0	13-00127	12-81	07-79	3,500	3,500	7,000	—	29	29	—
	0	13-00128	12-81	02-81	3,500	2,500	6,000	—	10	10	—
Physicians—No Major Surgery	0	13-00042	11-78	04-78	50,000	5,402	55,402	12,100.80	7	44	37
	0	13-00102	03-81	03-79	1,500	551	2,051	3,447.78	24	33	9
Family Phys. Gen.—No Surgery	1	13-00022	04-76	04-76	2,000	5,004	7,004	7,157.98	24	68	44
	1	13-00030	08-72	07-75	10,000	5,000	15,000	—	37	77	40
		TOTAL	68		1,082,810	248,622	1,331,432	132,455.47	420	648	228
		AVERAGE			15,923	3,656	19,579	1,947.87	6.2	9.5	3.5
		GRAND TOTAL	81		1,221,310	294,368	1,515,678	146,163.10	1799	3346	1547
		AVERAGE			15,077	3,634	18,712	1,804.48	22.2	41.3	19.1